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C.R.—Case Report (Clinical Notes).
Ed.—Editorial.
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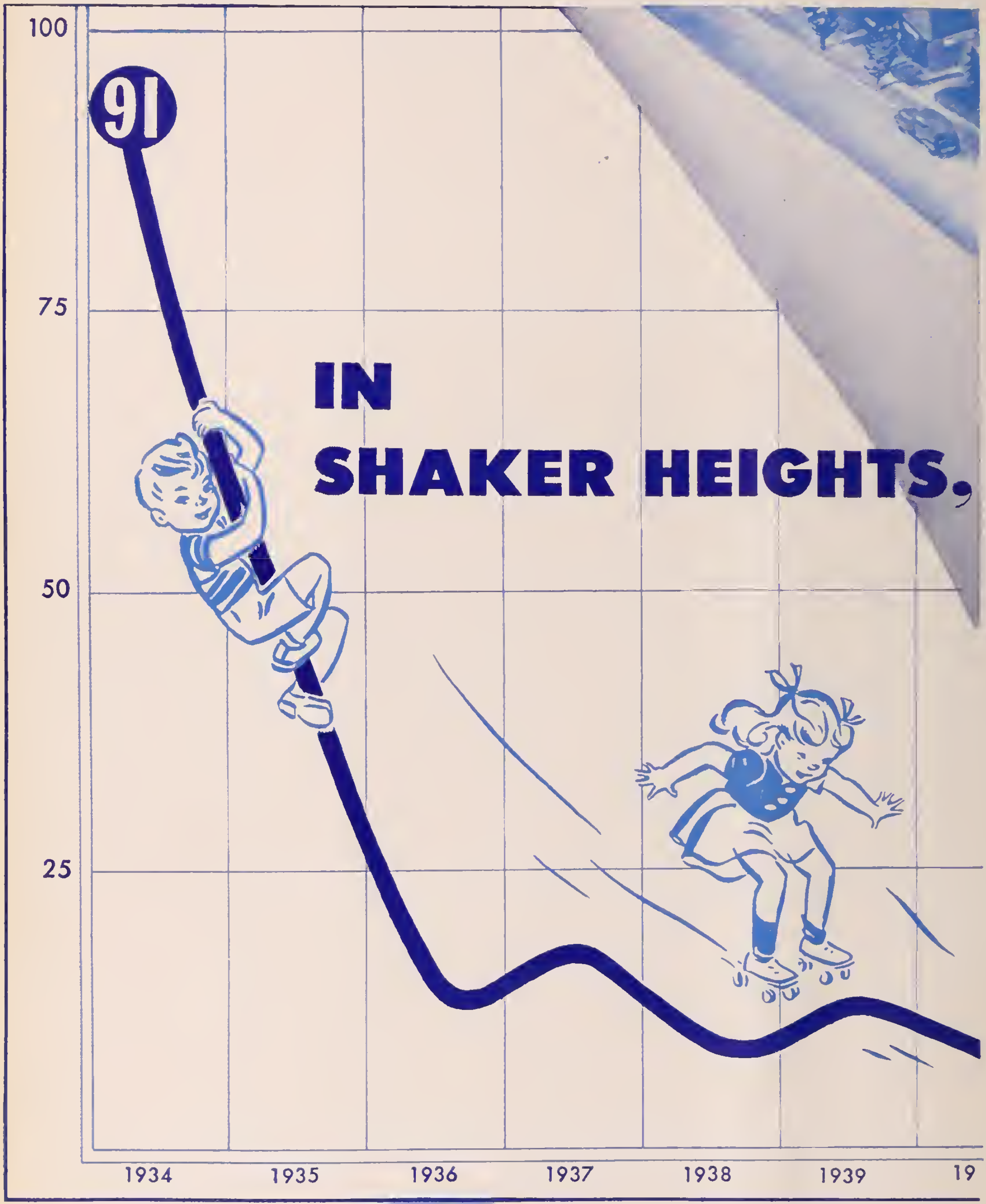
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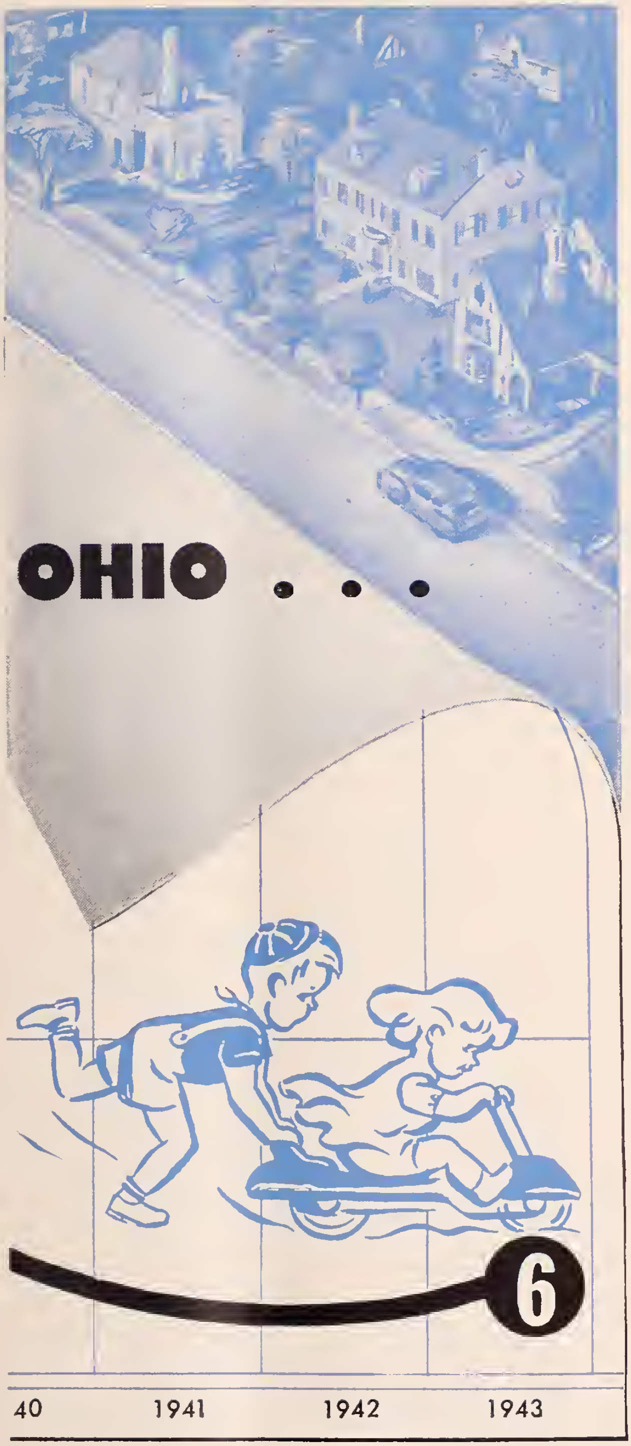

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[1] Garvin, J. A., Ohio State M. J. 41:229, 1945.

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Vice-Chairman—John W. Cline, 490 Post Street, San Francisco, 2.

Secretary-Editor—George H. Kress, 450 Sutter Street, Room 2004, San Francisco, 8.

Executive Secretary — John Hunton, 450 Sutter Street, Room 2004, San Francisco, 8.

General Counsel—Hartley F. Peart, Room 1800, 111 Sutter Street, San Francisco 4.

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In addition to the elected district and at-large Councilors, the Council has as ex-offico members the following general officers. President; President-Elect; Speaker; and the Association Secretary.

Council Officers: Philip K. Gilman, Chairman; George H. Kress, Secretary.

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Second District—Los Angeles County, Jay J. Crane (1948), 1921 Wilshire Boulevard, Los Angeles.

Third District—Inyo, Kern, Mono, San Luis Obispo, Santa Barbara and Ventura Counties, Harry E. Henderson (1946), 1421 State Street, Santa Barbara.

Fourth District—Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties, Axcel E. Anderson (1947), Medical Group Building, 1759 Fulton Street, Fresno.

Fifth District—Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz Counties, R. Stanley Kneeshaw (1948), 404 Medico-Dental Building, 241 East Santa Clara Street, San Jose.

Sixth District—San Francisco County, John W. Cline (1946), 1020 Medico-Dental Building, 490 Post St., San Francisco 2.

Seventh District—Alameda and Contra Costa Counties, Lloyd E. Kindall (1947), 400 Twenty-ninth Street, Oakland.

Eighth District—Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties, Frank A. MacDonald (1948), 822 Medico-Dental Building, 1127 Eleventh Street, Sacramento 14.

Ninth District—Del Norte, Humboldt, Lake Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma and Trinity Counties, John W Green (1946), Box 539, Vallejo.

Councilors-at-Large

Walter S. Cherry (1948), 109 N. Riverside Ave., Rialto, San Bernardino County.

Edwin L. Bruck (1948), 384 Post Street, San Francisco, 8.

Sidney J. Shipman (1947), 490 Post Street San Francisco 2.

E. Earl Moody (1947), 829 South Alvarado Street, Los Angeles.

Dewey R. Powell (1946), Room 501, 242 North Sutter Street, Stockton 2.

Edward B. Dewey (1946), Professional Building, 65 North Madison Avenue, Pasadena.

Standing Committees

Executive Committee

The President, the President-Elect, the Speaker of the House of Delegates, the Chairman of the Council, the Chairman of the Auditing Committee, the Secretary-Treasurer (ex officio), and the Editor (ex officio). John W. Cline, Chairman; George H. Kress, Secretary.

Auditing Committee*

John W. Cline (Chairman)	San Francisco	1945
Edwin L. Bruck	San Francisco	1945
Lloyd E. Kindall	Oakland	1945

Committee on Associated Societies and Technical Groups

John V. Barrow (Chairman)	Los Angeles	1946
Anthony B. Diepenbrock	San Francisco	1947
Edward F. Nippert	Hollywood	1948

Committee on Health and Public Instruction

J. C. Geiger (Chairman)	San Francisco	1946
E. Earl Moody	Los Angeles	1947
C. M. Burchfiel	San Jose	1948

Committee on History and Obituaries

Hyman Miller	Los Angeles	1946
Morton R. Gibbons, Sr. (Chairman)	San Francisco	1947
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Committee on Hospitals, Dispensaries and Clinics

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Roy E. Thomas	Los Angeles	1947
Clarence E. Rees (Chairman)	San Diego	1948

Committee on Industrial Practice

Carl L. Hoag	San Francisco	1946
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Donald Cass (Chairman)	Los Angeles	1948

Committee on Medical Defense

Louis J. Regan	Los Angeles	1946
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Committee on Medical Economics

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Wayne J. Pollock	Sacramento	1947
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B. O. Raulston (Chairman)	Los Angeles	1947
L. R. Chandler	San Francisco	1948

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Harold G. Trimble	Oakland	1948

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H. F. Freidell	Santa Barbara	1947
John C. Ruddock	San Diego	1948
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F. Burton Jones	Vallejo	1947
R. H. Sundberg	San Diego	1948
Secretary-Editor, ex officio		

Committee on Public Policy and Legislation

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Dwight H. Murray (Chairman)	Napa	1947
Lloyd E. Kindall	Oakland	1948
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H. R. Madeley (Vice-Chairman)	Vallejo
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J. Homer Woolsey	Woodland	1947
Howard F. West	Los Angeles	1948
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Eugene J. Joergenson	(ex officio, Secretary, Section on Surgery)	

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Nelson J. Howard	Chair., Com. on Medical Defense
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H. Gordon MacLean	Chair., Com. on Medical Economics
Dwight H. Murray	Chair., Com. on Public Policy and Legislation
F. E. Clough	Chair., Com. on Postgraduate Activities
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Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2004, 450 Sutter Street, San Francisco.

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Whitfield Crane (Vice-Chairman)	Oakland	1947
Gertrude Moore	Oakland	1947
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* Members appointed each year by the Chairman of the Council.

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Members who contemplate presentation of scientific papers should promptly address the secretary of the proper section, as per addresses which follow. Correspondence concerning scientific exhibits, and medical and surgical films, should be addressed to the Chairman of the Committee on Scientific Work: George H. Kress, M. D., 450 Sutter, San Francisco.

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Secretary, John A. Stiles, Stanford University Hospital, San Francisco.

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C.M.A. Committee on Scientific Work: For membership of State Association Committee, see roster on page 2, or address: Dr. George H. Kress, Chairman, 450 Sutter, San Francisco (8), Calif.

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(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
364 14th Street, Oakland 12
President, Warren B. Allen, 411 30th Street, Oakland 9.
Secretary, Dorothy M. Allen, 2923 Webster Street, Oakland 9.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, Hollis L. Carey, 567 Kentucky Street, Gridley.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, George Kelso, 416 E. Fourth Street, Pittsburg.
Secretary, H. F. Neufeld, Willow Pass Road, Concord.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, John E. Young, Rowell Building, Fresno.
Secretary, William L. Adams, Jr., 640 Terrace Avenue, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Walter Dolfini, 539 G Street, Eureka.
Secretary, Wayne P. McKee, Ferndale.
Meeting, *First Thursday.*

Imperial County Medical Society
President, T. E. Bartholomew, 319 Third Street, Calexico.
Secretary, Marian Hubbell, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, James Lloyd Mason, Bishop.
Secretary, Walter L. Wilson, 108 N. Main, Bishop.
Meeting, *Fourth Wednesday, except December, January, February.*

Kern County Medical Society
President, Sophie L. Goldman, 458 Haberfelde Building, Bakersfield.
Secretary, Juliet Thorner, 109 Eighteenth Street, Bakersfield.
Meeting, *Third Thursday, 7:30 p.m., Bakersfield Inn, except June, July, August.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, Fred J. Davis, Jr., 920 Pine Street, Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles 5
President, J. Jay Crane, 418 South Arden Street, Los Angeles 5.
Secretary, E. T. Remmen, 429 North Orange, Glendale 3.
Meeting, *First and Third Thursday, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Alex Miller, 1010 B Street, San Rafael.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, J. E. Gardner, 215 W. Standley Street, Ukiah.
Secretary, E. C. Bennett, Ukiah.

Merced County Medical Society
President, E. R. Fountain, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Margaret Swigert, Professional Building, Monterey.
Secretary, Sebastion Carnazzo, 411 Alvarado Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, Charles H. Bulson, 1203 Seminary Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, John Montanus, Rt. 1, Box 587A, Santa Ana.
Secretary, Russell I. Johnson, 181 Westminster Boulevard, Westminster.
Meeting, *First Tuesday, 7:00 p. m., Windsor Cafe, Santa Ana.*

Placer-Nevada-Sierra County Medical Society
President, George A. Foster, Grass Valley.
Secretary, Vernon W. Padgett, Grass Valley.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Franklyn D. Hankins, 3014 Pine Street, Riverside.
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Frank Reardon, Physicians Building, Sacramento
Secretary, Edmund E. Simpson, 1127 Eleventh Street, Sacramento 14.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, J. J. Haruff, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, J. J. H. Smith, 137 East H Street, Colton.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
President, A. E. Moore, 2120 Fourth Avenue, San Diego 1.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego, 1.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2190 Washington Street 9
President, Chester L. Cooley, 490 Post Street, San Francisco 2.
Secretary, Robertson Ward, 384 Post Street, San Francisco 8.
Meeting, *Second Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco, 9.*

San Joaquin County Medical Society
President, Dora Ames Lee, 110 North San Joaquin Street, Stockton 6.
Secretary, H. D. Chope, Box 111, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Edward C. Sherman, 784 Marsh Street, San Luis Obispo.
Secretary, G. D. Kelker, 1114 Marsh Street, San Luis Obispo.
Meeting, *Fourth Wednesday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, Logan Gray, 57 Fourth Avenue, San Mateo.
Secretary, J. Paul Sweeney, 1149 Rosewood Avenue, San Carlos.
Meeting, *At call of President.*

Santa Barbara County Medical Society
President, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Secretary, Charles A. Preuss, 1317 Santa Barbara Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, Charles A. Fernish, 226 Sainte Claire Building, San Jose 23.
Secretary, Fred W. Borden, Sainte Claire Building, San Jose, 23.

Santa Cruz County Medical Society
President, Ruth A. Frary, 123 East Third Street, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

Shasta-Trinity County Medical Society
President, L. C. Mosher, Bieber.
Secretary, Julius M. Kehoe, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, John W. Green, Box 539, Vallejo.
Secretary, Clark T. Alexander, 1607 Illinois Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.*

Sonoma County Medical Society
President, Kathleen G. Morris, 147 Kentucky Street, Petaluma.
Secretary, Robert S. Quinn, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, J. Lyle Spellman, P. O. Box 1412, Modesto.
Secretary, Richard R. Treadwell, P. O. Box 801, Modesto.
Meeting, *Second Friday, 7:30 p.m., Hotel Hughson.*

Tehama County Medical Society
President, James L. Faulkner, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Charles M. Mathias, 515 Kern Street, Tulare.
Secretary, James C. Malcolm, 1501 West Main, Visalia.

Ventura County Medical Society
President, A. W. Cruden, Saticoy.
Secretary, George H. Arnold, Route 2, Box 12, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Charles S. Roller, 604 Woodland Avenue, Woodland.
Secretary, Emery Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, Leon M. Swift, 1914 Greely Drive, Marysville.
Secretary, Thomas F. Keyes, 725 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

(For roster of C.M.A. committees and other organization, see last month's issue.)

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Hospital Service of Southern California, 743 South Grand View Street, Los Angeles. (Phone DRexel 5261.)

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento. (Main 2548.)

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WEst 8000, Extension 75.

Barlow Medical Library (Los Angeles County Medical Association), 634 So. Westlake, Los Angeles 5. Phone FItzroy 7694.

Note.—The Library of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, also maintains a medical literature packet service.

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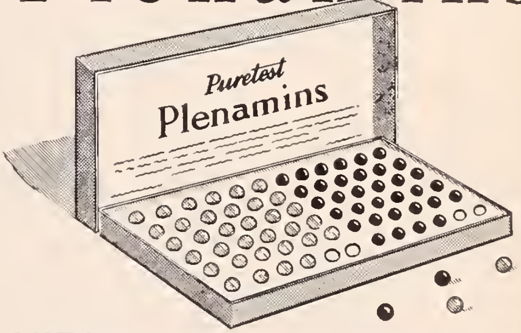

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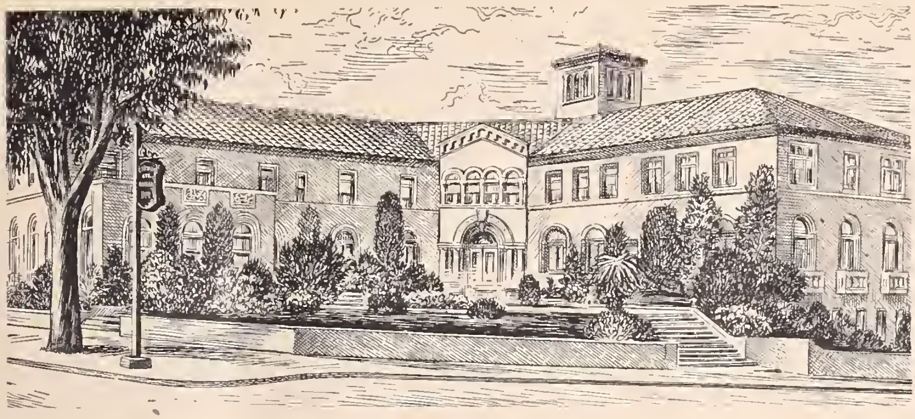

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BOOK REVIEWS

BOOKS RECEIVED

Manual of Diagnosis and Management of Peripheral Nerve Injuries. By Robert A. Groff, M.D., Lieutenant Colonel, M.C., A.U.S., formerly Assistant Professor of Surgery, Jefferson Medical College, and Assistant Professor of Neurosurgery, Graduate School of Medicine, University of Pennsylvania; and Sara Jane Houtz, B.S., First Lieutenant (P.T.) A.U.S., with an Introduction by I. S. Ravdin, M.D., Brigadier General, M.C., A.U.S.; John Rhea Barton, Professor of Surgery, University of Pennsylvania. Cloth. Price, $8.00, with 111 original illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1945.

The Psychoanalytic Theory of Neurosis. By Otto Fenichel, M.D. Cloth. Price, $7.50. Pp. 703. New York: W. W. Norton & Company, Inc., 1945.

Annual Report of the Baruch Committee on Physical Medicine. For the Fiscal Year April 1, 1944 to March 31, 1945. 595 Madison Avenue, New York 22, N. Y. For: Bernard M. Baruch. By: Ray Lyman Wilbur, *Chairman;* Frank H. Krusen, *Director;* John Stanley Coulter; John F. Fulton; Charles Gordon Heyd; Andrew C. Ivy; Chauncey D. Leake; Frank R. Ober; Winfred Overholser, and Francis O. Schmitt. Paper. Pp. 82, 1945.

The Cap and Gown Stanford Calendar 1946. Published for the Benefit of the Cap and Gown Scholarship Fund for Leland Stanford Junior University. Paper. Price, $1.00, illustrated. Stanford University (P.O.): Stanford University Press, 1945.

(Continued on Page 12)

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THE CITY OF BENICIA is offering for sale the following medical equipment. Sealed bids will be accepted on or before February 14, 1946. Description of the equipment being offered for sale and bid forms may be obtained from the City Clerk, Box 35, Benicia, California. The following is a partial list of the items being offered: 115-V 60 Cy. Model D-3 Combination Radiographic and Fluroscopic, Shockproof Mobile X-Ray Unit, XRP Hand Fluroscope with Patterson Type B screen 8x10, 3 dozen Back Rests, 1 Medical Cabinet, 1 Cincinnati Treatment Chair, 12 Mayo Instrument Tables, 1 Universal Operating Table, 1 Castle Surgery Light with Battery, 1 Stokes Stretcher. 2 Bradford Frames, 1 McKesson Model L. Nargraf No. 925, 6 Blake Lyle (ks) Fracture Frames, Forceps, glass needle boxes, mosquito forceps, sponge sticks, and other medical and surgical equipment and instruments.

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write

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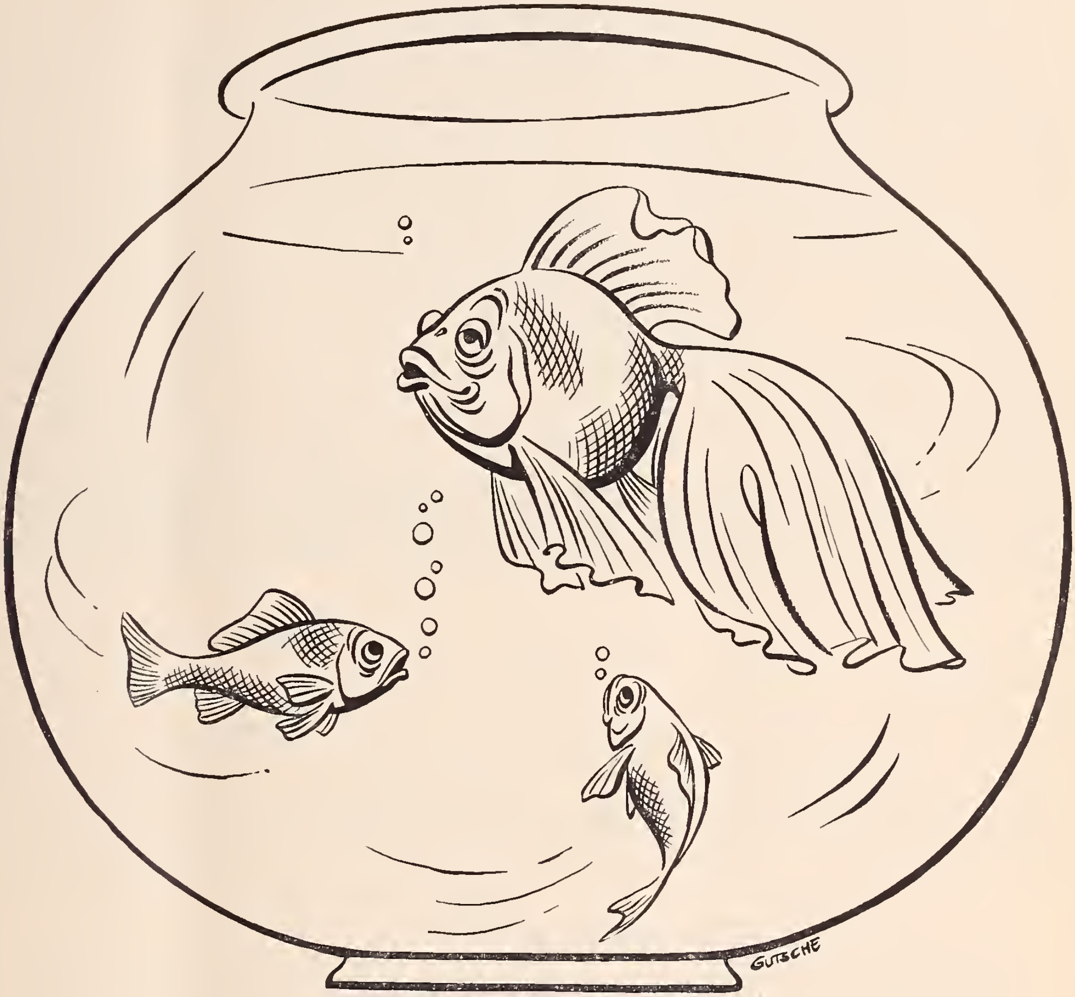

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BOOKS RECEIVED

(Continued from Page 7)

The Extremities. By Daniel P. Quiring, Ph.D., Head of the Anatomy Division, Cleveland Clinic Foundation and Associate Professor of Biology, Western Reserve University; Beatrice A. Boyle, Artist Cleveland Clinic Foundation; Erna L. Boroush, M.A., Fellow Anatomy Division, Cleveland Clinic Foundation; and Bernardine Lufkin, A.B., former Secretary Research Division, Cleveland Clinic Foundation. Cloth. Price, $2.75. Pp. 117, illustrated with 106 engravings. Philadelphia: Lea & Febiger, 1945.

Local Health Units For the Nation. A Report by Haven Emerson, M.D., Chairman, Subcommittee on Local Health Units, Committee on Administrative Practice, American Public Health Association. With the collaboration of Martha Luginbuhl, M.D. Paper. Price, $1.25. Pp. 333, illustrated. New York: The Commonwealth Fund, 1945.

BOOK REVIEWS

Local Health Units For the Nation. A Report by Haven Emerson, M.D., Chairman, Subcommittee on Local Health Units, Committee on Administrative Practice, American Public Health Association. With the collaboration of Martha Luginbuhl, M.D. Paper. Price, $1.25. Pp. 333, illustrated. New York: The Commonwealth Fund, 1945.

A valuable public health service has been rendered by the Commonwealth Fund of New York City in bringing off the press "Local Health Units For the Nation," a volume of some 333 pages, 8 by 10.

The book, edited by Haven Emerson, contains many valuable suggestions concerning urban and rural health needs. It is of interest to note that this report was gathered under the sponsorship of a group of state and local pubilc health administrators, acting as the Committee on Administrative Practice of the American Public

(Continued on Page 16)

Harvesting influenza virus from chick extraembryonic fluids

Now It Can Be Told

● The prevalence of Influenza during World War I stimulated increased research for better immunizing agents to control this dread disease.

Since 1933 when Smith, Andrewes and Laidlaw isolated a filtrable virus from patients ill with clinical influenza and established the viral etiology of the disease, numerous attempts to develop a prophylactic vaccine have been made.

Burnet, Henle, and Nigg obtained a high concentration of virus in chick extraembryonic fluids; and vaccines made from such fluids were subsequently studied by a large number of investigators. Some degree of efficacy of these vaccine preparations was shown both by antibody response and by protection against experimental infection of test animals and of human beings.

Although for security reasons the fact has not been previously revealed, the Pitman-Moore Laboratories are now proud to list such a vaccine among the prophylactic and therapeutic medicines of which it has supplied large quantities to the armed forces.

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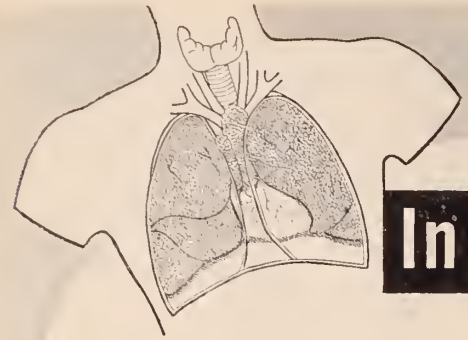

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Since penicillin has become available in quantities that may well be adequate for all needs, it merits being the physician's first thought with every pneumonia patient.

*Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

McBryde, A.: Hemolytic Staphylococcus Pneumonia in Early Infancy; Response to Penicillin Therapy, Am. J. Dis. Child. 68:271 (Oct.) 1944.

Stainsby, W. J., Chairman, Commission for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania: Up-to-Date Facts on Pneumonia, Pennsylvania M. J. 48:266 (Dec.) 1944.

Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:272 (July-Aug.) 1944.

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Penicillin-C.S.C. deserves the physician's preference not only in the pneumonias, but whenever penicillin therapy is indicated. Rigid laboratory control in its manufacture, and bacteriologic and biologic assays, safeguard its potency, sterility, nontoxicity, and freedom from pyrogens. The state of purification reached in Penicillin-C.S.C. is indicated by the notably small amount of substance required to present 100,000 Oxford Units. Because of this purity, incidence of the undesirable reactions, attributed by many investigators to inadequate purification, is greatly reduced.

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With his "fussy" appetite, intestinal upsets and restless sleep, you'd think he was 70 years instead of 7 weeks old. A change to 'Dexin' brand High Dextrin Carbohydrate formulas often helps restore a normal, healthy appetite, and sound, undisturbed sleep. The high dextrin content of 'Dexin' (1) diminishes intestinal fermentation and the tendency to colic and diarrhea, and (2) promotes the formation of soft, flocculent, easily digested curds.

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F. E. YOUNG & COMPANY, 432 E. 75th St., Chicago 19, Illinois

BOOK REVIEWS

(Continued from Page 12)

Health Association, of which committee Wilton L. Halverson, M.D., California Director of Public Health, is the chairman.

The volume is divided into the following sections: (1) Principles; (2) Definitions and Sources of Data; (3) Local Public Health Services Existing and Proposed in the United States; (4) Present and Suggested Personnel and Costs for Local Health Services for each State and the District of Columbia; (5) State Laws Requiring or Authorizing the Creation of Local Health Jurisdictions.

The discussion of California conditions is given on pages 41 to 47, and presents much valuable information. It is stated that in 1940 seventy per cent of California's population was classified as urban and that of its 2,525,000 persons employed, about one-sixth were engaged in manufacturing and that ten per cent were in agriculture. The estimated per capita spendable income in 1941 was $948.00, higher than in any but two of the 48 states. General hospital beds totaling 39,916 were reported in 1940, or an average of 5.8 per 1,000 population. Approximately one practicing physician for every 630 persons in the State was reported in 1940; in San Francisco County the ratio was 1 to 360; in none was it as low as 1 to 1,500.

Comment was made concerning the basic public health law of California and more recent additions, through

(Continued on Page 17)

The Devereux Foundation

Santa Barbara, California Devon, Pennsylvania

will present a Certificate of Merit and a Five Hundred Dollar Award for the outstanding paper contributed on Research in Child Psychiatry, as selected by the Committee on Research of the American Psychiatric Association.

The Devereux Schools cordially invite all those interested in this field to participate and to submit papers by March 1. Papers will be returned to contestants.

The rules governing the Award may be secured from Mr. Austin M. Davies, Executive Assistant of the American Psychiatric Association, Room 924, 9 Rockefeller Plaza, New York 20, N. Y.

Presentation will be made at the Devereux Invitation Luncheon held during the meeting of the

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May 27-30, 1946 Palmer House, Chicago, Illinois

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Medical Directors, Pasadena, California

BOOK REVIEWS

(Continued from Page 16)

which district activities may be carried on. The volume is worthy of inspection by all who have professional or other interest in public health activities.

The Cap and Gown Stanford Calendar 1946. Published for the Benefit of the Cap and Gown Scholarship Fund of Leland Stanford Junior University. Paper. Price, $1.00, illustrated. Stanford University (P.O.): Stanford University Press, 1945.

The Stanford University Press of Stanford University, California, has brought off the press a 1946 calendar with excellent illustrations of the Stanford buildings, farm and surrounding territory. The Calendar is published for the benefit of the Cap and Gown Scholarship Fund of the Leland Stanford University. Readers who use calendars for memoranda will find this booklet not only useful, but because of its excellent illustrations, most enjoyable. An illustration faces each of the calendar pages.

TWENTY-FIVE YEARS AGO

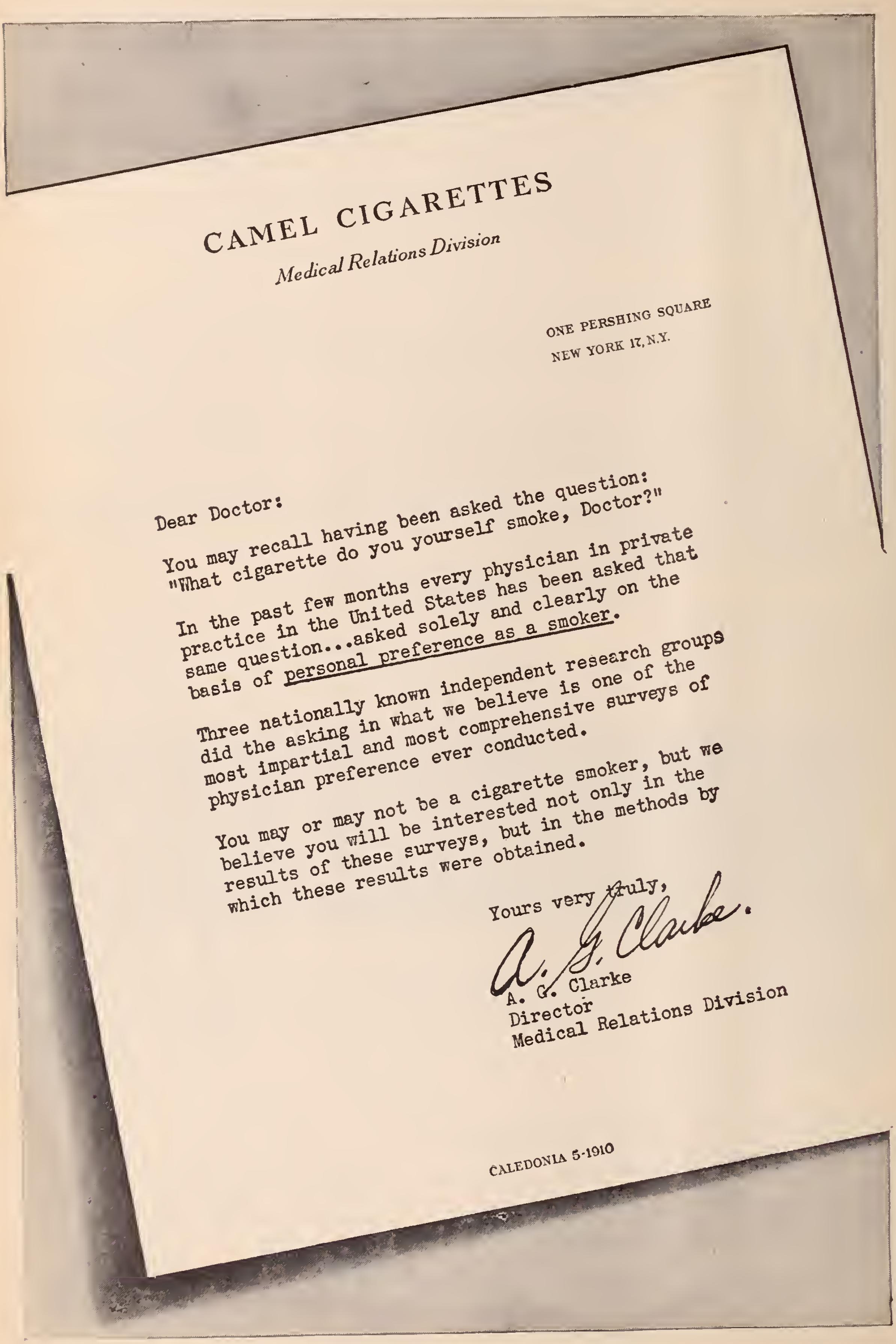
(Continued from Text Page 62)

tionists it drew from them this loving message to Dr. Keen:

"Arch Fiend:

We read with horror your article in the Ladies' Home Journal on vivisection. We hope your mother if she is living will die in the most horrible torture, and if she is dead that her soul will never know rest for having given life to such a vile monster as you,

(Continued on Page 22)



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You may recall having been asked the question: "What cigarette do you yourself smoke, Doctor?"

In the past few months every physician in private practice in the United States has been asked that same question...asked solely and clearly on the basis of personal preference as a smoker.

Three nationally known independent research groups did the asking in what we believe is one of the most impartial and most comprehensive surveys of physician preference ever conducted.

You may or may not be a cigarette smoker, but we believe you will be interested not only in the results of these surveys, but in the methods by which these results were obtained.

Yours very truly,

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Director
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A physician asked us the question first—

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We know that many physicians smoke, that many of them prefer Camels; but we couldn't answer the doctor's query.

We turned the question over to three nationally known independent survey groups. For months these three groups worked . . . separately . . . each one employing the latest scientific fact-finding methods.

This was no mere "feeling the pulse" poll. No mere study of "trends." This was a nationwide survey to discover the actual fact . . . and from the statements of physicians themselves.

> *To the best of our knowledge and belief, every physician in private practice in the United States was asked: "What cigarette do you smoke?"*

The findings, based on the statements of thousands and thousands of physicians, were checked and re-checked.

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Naturally, as the makers of Camels, we are gratified to learn of this preference. We know that no one is more deserving of a few moments to himself than the busy physician . . . of a few moments of relaxation with a cigarette if he likes. And we are glad to know that so many more physicians find in Camels the same added smoking pleasure that has made Camels such an outstanding favorite among *all* smokers.

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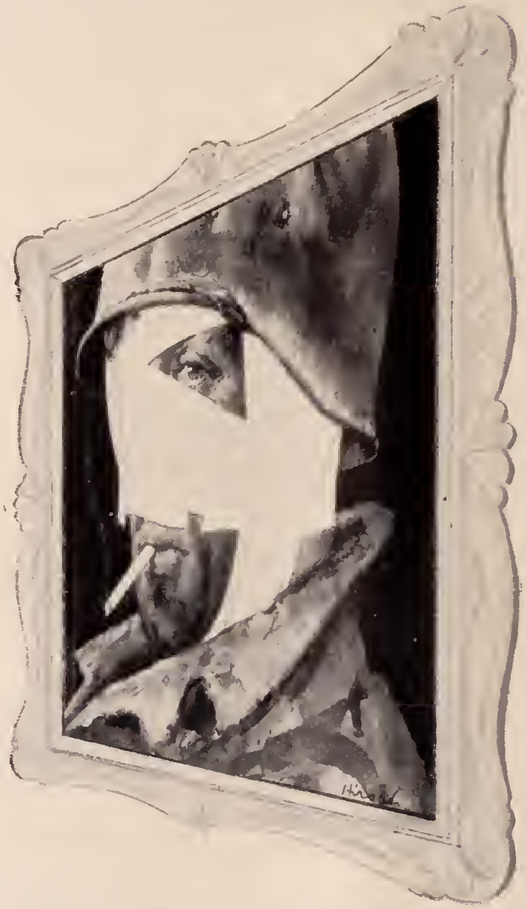

Abbott Laboratories is proud to announce that the Abbott Collection Paintings of Army Medicine is to be shown to the public at the M. H. DeYoung Memorial Museum, in San Francisco, from January 22 through February 17. • Through the cooperation of the United States Army, twelve of America's most distinguished artists, commissioned by Abbott Laboratories, were enabled to make this complete pictorial record of Army Medicine. Armed only with palette and brush the artists risked their lives voluntarily and repeatedly to cover every theater of war where American troops fought. • It is hoped that all friends of Abbott will find it possible to attend. Abbott Laboratories, North Chicago, Illinois.

M. H. DeYoung Memorial Museum,

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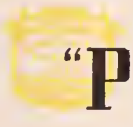
In Estrogenic Therapy . . . TOLERANCE

One of the important advantages of "Premarin" lies in the fact that it is exceptionally well tolerated. Although highly potent, "Premarin" rarely produces unpleasant side effects—a statement which finds ample corroboration in the extensive bibliography. In "Premarin" the physician will find a medium for estrogenic therapy which is noted for its therapeutic effectiveness. "Premarin" is derived exclusively from natural sources and its administration is usually followed by what is invariably described by the patient as a general feeling of well-being.

ESSENTIALLY SAFE • HIGHLY POTENT • ORALLY ACTIVE
NATURALLY OCCURRING • WATER SOLUBLE
WELL TOLERATED • IMPARTS A FEELING OF WELL-BEING



"Premarin" *conjugated estrogens (equine)*
Reg. U. S. Pat. Off
TABLETS

Available in 2 potencies. No. 866 (the YELLOW tablet), in bottles of 20, 100 and 1,000 tablets.
No. 867 Half-Strength (the RED tablet), in bottles of 100 and 1,000 tablets.

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AYERST, McKENNA & HARRISON LTD., 22 East 40th Street, New York 16, N. Y.

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In Congestive Heart Failure

For the reduction of edema, to diminish dyspnoea and to strengthen heart action, prescribe Theocalcin, beginning with 2 or 3 tablets t.i.d., with meals. After relief is obtained, the comfort of the patient may be continued with smaller doses. Well tolerated.

Theocalcin, brand of theobromine-calcium salicylate, Trade Mark reg. U. S. Pat. Off.

Available in 7½ grain tablets and in powder form.

Bilhuber-Knoll Corp. Orange, N. J.

TWENTY-FIVE YEARS AGO

(Continued from Page 17)

is the nightly prayer of a dozen women who indited this."

No names were signed to this sympathetic message, but it bore the Los Angeles postmark. The $100,000 might well be devoted to supplying the milk of human kindness to this angelic dozen.

The first time that the people ever rendered a verdict upon the value of vivisection was in California on November 2, 1920. By the overwhelming majority of 254,842 the people of this state placed their firm stamp of approval on scientific progress. Every county of California repudiated the cruel charges and baseless claims of the anti-vivisectionists. The result was not an accident. It was produced by a well-directed campaign that placed the facts persuasively before the people. . . .

Fundamentals of Nutrition.—American scientific men have been credited with lagging behind the rate of progress shown in Europe in the domain of medicine. Surgery has come fully into its own in the western hemisphere, but American medicine is held too often to be engaged solely in practicing and teaching, and too little in investigating. Among many one of the finest refutations of this mistaken notion is found in the impetus given by American scientists to our understanding of dietetics and food values, and the use of diet in the prevention and cure of disease. . . .

Chinese Herbalists Vie with Chiropractors in Breaking the Laws.—"For ways that are dark, and for tricks that are vain." The Chinese herbalist is having a hard time maintaining the lead since the unlicensed chiropractors have entered the field. Their ancient solitary reign is distinctly disturbed. Since the last issue of the JOURNAL the chiropractors have fattened their lawbreaking batting average. The "Herbalists," however, are still contenders for lawless honors. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Problems of Enforcement of the Medical Act," by Charles B. Pinkham, M.D., San Francisco.—Perusal of correspondence as well as conversation with various practicing physicians of California discloses a surprising paucity of knowledge (1) regarding the operation of the investigation and legal departments of the Board of Medical Examiners and (2) regarding the difficulties encountered in their endeavors to discourage violations of the Medical Practice Act.

The question is frequently asked: "Why the necessity of the enforcement machinery of the Board when each county provides a District Attorney whose principal function is to prosecute individuals who are charged with violation of the law?" Experience has taught the truth of the adage: "What is everyone's business is no one's business," and we have also learned that satisfactory prosecution of a charge of violation of the Medical Act demands the services of an attorney well versed in the medical law; hence the Legal and Investigation Departmetn is requisite for enforcement. . . .

From an Article on "The Present Nursing Situation," by W. W. Roblee, M.D., Riverside.—During the past half century the practice of medicine under the stimulus of such epochal development as has come through the great discoveries of bacteriology, pathology, chemistry, phar-

(Continued on Page 26)

Want better protection . . .

. . . Policy coverage is no better than the service by which it is administered.

for greater malpractice hazards? . . .

. . . Prevailing unrest multiplies the dangers in every doctor's practice. His protection should therefore be more than good.

Use Specialized Service!

. . . Even if all policies were the same, Specialized Service would still put the "plus" in Medical Protection.

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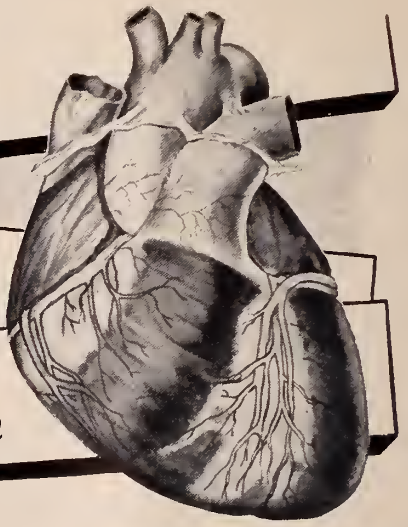
Fort Wayne, Indiana

The chief active glycoside of Digitalis purpurea...

as effective by mouth as by vein...

virtually free from nausea and vomiting due to local action



DIGITALINE NATIVELLE presents the chief active glycoside of Digitalis purpurea, in pure, crystalline form, freed from the inert, unabsorbable material contained in the leaf preparations.

It is absorbed quantitatively, probably directly from the stomach. Its oral administration is not beset by local irritant action—nausea and vomiting from gastric irritation are virtually never encountered.

Since it is absorbed in toto, its action is the same—and its digitalizing effect is accomplished with practically the same speed—whether it is given orally or by the intravenous route.

The cardiac action of one 0.1-mg. tablet of Digitaline Nativelle equals that of one 1½-gr. tablet of digitalis leaf preparations. Hence no greater caution is required when Digitaline Nativelle is used, no different instructions are needed for the patient, when initial digitalization is in the customary divided dosage. *But the side actions attending the leaf preparations—nausea and vomiting due to local irritation—need be of no concern.* The only change is that one 0.1-mg. tablet of Digitaline Nativelle is used for each of the formerly used 1½-gr. tablets or capsules of digitalis leaf.

An added advantage is that Digitaline Nativelle—completely absorbed and free from locally caused vomiting—in urgent cases permits of rapid digitalization by mouth, with an average dose of 1.2 mg. (12 tablets 0.1 mg. each or 6 tablets 0.2 mg. each) administered at one time.

For maintenance, a dosage of 0.1 mg. daily is recommended, to be increased or decreased as required by the individual.

Digitaline Nativelle is reasonably priced, within reach of every patient.

DIGITALINE NATIVELLE
40 TABLETS
DIGITALINE NATIVELLE
EACH TABLET CONTAINS
0.1 mg.

Physicians are invited to send for samples, literature, and bibliography.

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To those of you who left your homes to serve your country we extend a warm and friendly welcome, a happy welcome home. The extraordinary service the medical profession gave in the war can't be told here. Here we want to say how glad we are to have you back again, away from the heavy change of war; back into your proper sphere, back again into your peace-time practice, back to a long, peaceful, happy service in the nation's health. ▸ ▸ ▸ Back again at home, in your own country.

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KEVIN McGETTIGAN
Manager

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SAN FRANCISCO.

TWENTY-FIVE YEARS AGO

(Continued from Page 22)

macology, physics and the other branches of true science, has undergone a complete metamorphosis. . . .

We have not only grown to depend upon the trained nurse for the care of patients in hospital, but we have been educating the public to ask for nursing service in the home, and to use these women for much of the detail work in the great public health and social betterment movements in practically every community. This furnishes an outlet for the energy and enthusiasm of the best type of young womanhood along lines of personal and social service for which women are preëminently fitted.

We older men who have been privileged to watch the development of this noble group of women, have been tremendously impressed with their value and usefulness and have counted it a privilege to have had some part in it. . . .

From an Article on "A Plea for Better Fracture Results," by George J. McChesney, M.D., San Francisco.—In no branch of surgery have we learned more from our war experience than in the treatment of fractures, and now is the time to apply that dearly-bought knowledge before it becomes a dim memory. . . .

What in brief are the principles emphasized by the war treatment of fresh fractures:

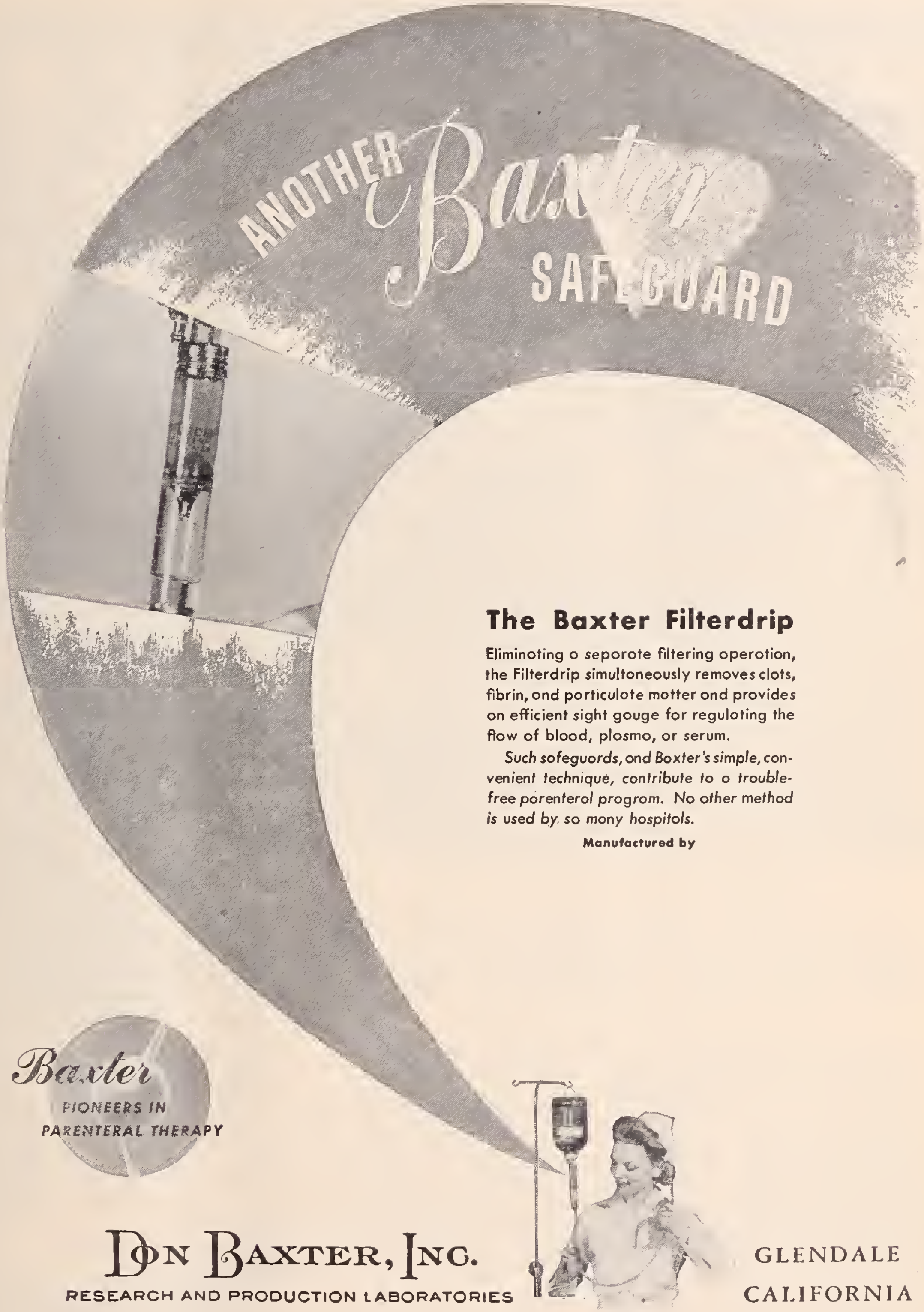
(1) That the traction method of treating fractures, now nearly perfected, should be used much oftener.

(2) That meticulous or geometric accuracy of approximation is not necessary for good function.

(3) That metallic fixation or internal splinting is never absolutely necessary.

(4) That as a consequence, operations are needed much less than is the practice at present. . . .

(Continued on Page 30)



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Eliminating a separate filtering operation, the Filterdrip simultaneously removes clots, fibrin, and particulate matter and provides an efficient sight gauge for regulating the flow of blood, plasma, or serum.

Such safeguards, and Baxter's simple, convenient technique, contribute to a trouble-free parenteral program. No other method is used by so many hospitals.

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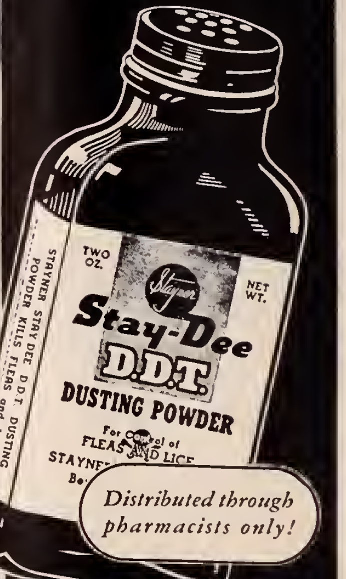
"DDT insecticides were credited with a military and civilian importance equal to penicillin and plasma . . ." *Britannica Book of the Year, 1945.*

"The use of DDT in concentrations up to 10% in inert powders for dusting clothes, and in the extermination of lice, appears to offer no serious hazards because of the relative insolubility of DDT and the large particle size of the dust."— *Supplement 177 to Public Health Reports, Federal Security Agency, U. S. Public Health Service.*

To control body insects prescribe Stay-Dee DDT Dusting Powder

Stay-Dee is a carefully compounded mixture containing 7½% of DDT (dichloro-diphenyl-trichloroethane), equivalent to 10% of technical grade, combined with inert extenders and stabilizers. It is especially prepared for the control of FLEAS, and HEAD, BODY and PUBIC (Crab) LICE, and may be used with safety on the human skin. It has a flesh color and a pleasant odor, and is packaged in an amber bottle with a convenient shaker top. Prescribe Stay-Dee DDT Dusting Powder with confidence for the eradication of body insects—all western pharmacists now have it available.



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PHYSICIANS are invited to write for a regular 2-ounce bottle of Stay-Dee DDT Dusting Powder (7½%) which will be sent without charge or obligation.

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"WELL, DOCTOR, I'D PUT THIS BABY ON DRYCO"

"His condition requires careful dietary supervision – with Dryco you can easily adjust the formula to meet his requirements."

Because Dryco offers the physician wide limits of formula flexibility, it is ideally suited to *special* feeding . . . besides being perfectly suited to *normal* cases. It may be prescribed with or without added carbohydrate . . . and may be employed in *concentrated* form also when indicated.

The high-protein, low-fat ratio of Dryco (2.7 to 1) assures optimum protein intake and minimal gastro-intestinal upsets from fat indigestion. In addition, Dryco contains adequate vitamins A, B_1, B_2, and D, plus essential milk minerals.

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DRYCO *is made from spray-dried, pasteurized, superior quality whole milk and skim milk. Provides 2500 U.S.P. units vitamin A and 400 U.S.P. units vitamin D per reconstituted quart. Supplies 31½ calories per tablespoon. Available at all drug stores in 1 and 2½ lb. cans.*

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For the Diagnosis and Treatment of Nervous and Mental Illness.

THE SOUTHARD SCHOOL

For the Education and Psychiatric Treatment of Children of Average and Superior Intelligence. Boarding Home Facilities.

TOPEKA, KANSAS

TWENTY-FIVE YEARS AGO

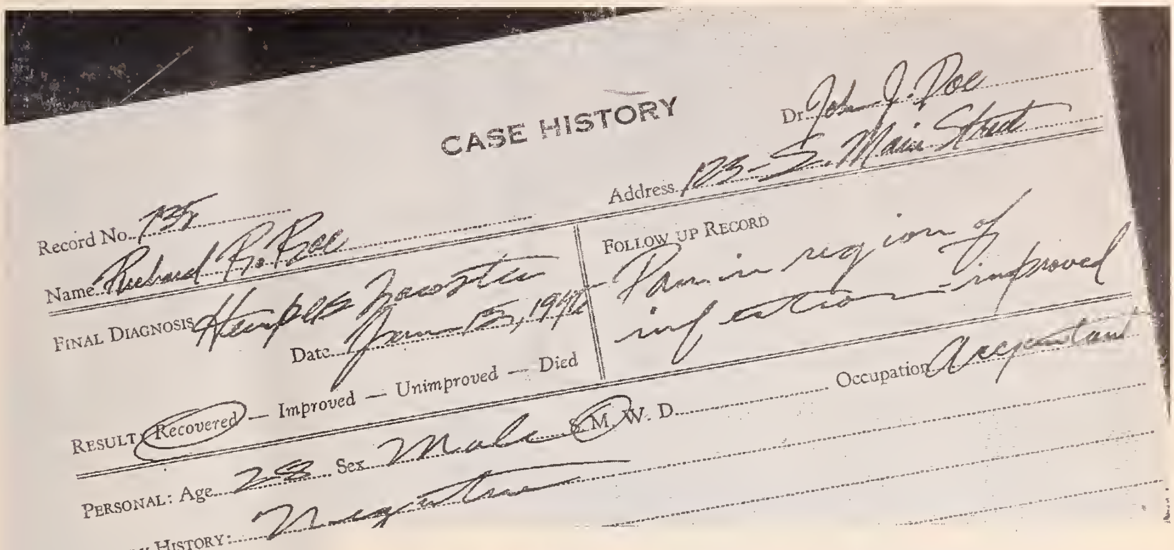
(Continued from Page 26)

From an Article on "Practical Points in Using Thomas Splints," by Sterling Bunnell, M.D., San Francisco.—The Thomas splint well merits the permanent popularity which it has gained. By its use most fractures of long bones can be better treated than by the open operation method and the dangers from the latter can be avoided. The old rule of immobilizing the joint above and the joint below the fracture resulted in loss of function of these joints and a long period of disability in regaining this loss of function. With the Thomas splint the joint above and the joint below are kept mobilized, so that function of them is not lost. Its economy, traction principle, ease of application and adaptability to open fractures make it far more serviceable than the plaster of Paris cast. For transportation it is unexcelled, and all first-aid stations should keep Thomas splints on hand. The successful use of the Thomas splint necessitates attention to many details, some of which are enumerated in this paper. . . .

From an Article on "Improved Incision for the Fredet Rammstedt Operation," by Edmund Butler, M.D., San Francisco.—The epigastric right rectus or midline incision is the usual portal of approach in performing the Fredet Rammstedt operation. The closure of these incisions is fraught with many technical difficulties that tend to prolong the time of operation and resulting often in various postoperative complications. . . .

The improved incision, called "the flood gate incision," for want of a more appropriate name, does away with the above described difficulties and complications This incision is made over the quadrate lobe of the liver above

(Continued in Back Advertising Section, Page 34)



CASE HISTORY

Dr. John J. Doe

Address 123 S. Main Street

Record No. 735

Name Richard R. Roe

FOLLOW UP RECORD Pain in region of infection — improved

FINAL DIAGNOSIS Herpes Zoster

Date Jan 15, 1946

RESULT: [✓ Recovered] — Improved — Unimproved — Died

S. [✓ M.] W. D. Occupation Accountant

PERSONAL: Age 29 Sex Male

FAMILY HISTORY: Negative

HABITS:

PAST HEALTH:

PRESENT CONDITIC

PHYSICAL E

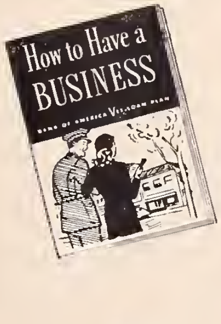
TEMP

HEAD: (i

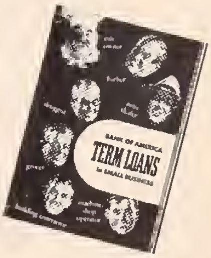
CASE HISTORY OF ONE DOCTOR IN 2500—

Dr. ———, one of 2500 members of California Medical Association serving in World War II, recently returned to civilian life. When discharged, desired to enter group practice. Took advantage of "G. I. Bill of Rights," which guarantees certain veteran loans up to 50% or $2,000. Under Bank of America's **Vet-Loan Plan**, was extended credit totaling $5,300—enough for good start in group practice. Repaying **Vet-loan** in convenient monthly payments.

Whether or not you are a veteran, **Timeplan** loans are available for your every need—building or modernizing home or office, buying medical equipment or an automobile. Drop in and talk over your plans at Bank of America.



"How to Have a Business" and "Term Loans for Small Business" are two helpful Bank of America booklets which you might like to read. They are yours for the asking at any branch.



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Adequate rest is an important factor in the successful treatment of upper respiratory infections. Frequently, nasal congestion keeps the patient irritable and sleepless. Solution 'Tuamine Sulfate' (2-Aminoheptane Sulfate, Lilly), administered by spray or dropper, quickly shrinks the nasal mucosa, permitting easy, natural breathing. There is no secondary engorgement or central-nervous-system stimulation. Specify Solution 'Tuamine Sulfate,' 1 percent, for home use. The 2 percent solution is recommended for office procedures in which maximum shrinkage is required.

Lilly ELI LILLY AND COMPANY, *Indianapolis 6, Indiana, U.S.A.*

CALIFORNIA
AND
WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 64 JANUARY, 1946 NO. 1

California and Western Medicine

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Phone DOuglas 0062

Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . GEORGE H. KRESS, M. D.

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

Committee on Publications

George W. Walker, Chairman..........Fresno 1946
F. Burton Jones......................Vallejo 1947
R. H. Sundberg.......................San Diego 1948
George H. Kress, Secretary-Editor......San Francisco ex officio

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . . JOHN HUNTON

Advertising Representative for Northern California
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Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

GREETINGS—1946 WILL BE A READJUSTMENT YEAR IN MEDICINE

Current Reconversion Problems.—World War II in its active phases, with VE- and VJ-days behind us, now belongs to history.

Today, "Reconversion Days," or perhaps, for the medical profession, "Readjustment Days," face not only the 60,000 colleagues who have or are returning from military life, but also the many thousands of physicians who, under unusual conditions, have been carrying on civilian practice since Pearl Harbor Day of December 7, 1941.

Whatever credit may be due to members of the medical profession who were in civilian practice for hard work during the war period, to them, appreciation has been and is again tendered.

However, to those Doctors of Medicine, men and women, who placed themselves in service for our Country, special meed of praise and thanks are due, and to all such, in California and other States, generous tribute by their non-military fellows is gladly expressed.

* * *

One Way to Show Appreciation to Returning Military Colleagues.—It is important to keep in mind that military colleagues who return to their former places of practice, only to learn that they cannot find office facilities in which to take up civilian activities, cannot feel other than somewhat disillusioned.

It is granted that space in office buildings is at a premium under existing postwar housing conditions, but there is no reason why office facilities during certain hours may not be shared between two or more physicians, particularly when by so doing, coöperation will be given to physicians coming back from the Armed Services, and who wish again to take up their work in private practice.

For the metropolitan centers of the Great Southwest, it must be acknowledged that many physicians actually use their office space for only a comparatively small part of the time available. This is in strong contrast to some of the office arrangements in vogue in the loop district of Chicago and in other Eastern cities, where the same suite of rooms may be used for two- and three-hour periods by a group of physicians who follow one another in turn, and who in spite of some inconveniences, carry on their office practices in quite harmonious manner under such conditions.

From what has been stated, the suggestion may be inferred that it would seemingly be in order, when the glad hand of fellowship is extended to returning military colleagues, to give the word greetings due expression in deed as well, by offering office facility participation whenever circumstances may indicate such need and action.

* * *

Agitation for Changes in Medical Practice Continues.—In the year now beginning, the medical profession will be confronted with many readjustment problems. The world is changing, social and other relationships of the times are changing, and some of the procedures in medical practice are also undergoing change.

In their devotion to practice of the healing art, physicians should not become so engrossed in service to sick individuals or groups of patients in hospitals, to permit themselves to ignore the agitation that is in evidence throughout the land; the purpose of which is to bring into being through what are little less than revolutionary procedures, certain changes in medical practice that could seriously affect the capacity of the medical profession to render a high quality of healing art service.

High standards in medical care can only be maintained if, in addition to excellent work by each individual physician, group spirit and loyalty to the guild to promote the good and advancement of the whole, also prevail.

† † †

For the year 1946, as in years past, California and Western Medicine again extends greetings and good wishes to all members of the California Medical Association.

May the coming year measure up to our highest hopes!

LOS ANGELES COUNTY MEDICAL ASSOCIATION WILL CELEBRATE THE 75TH ANNIVERSARY OF ITS FOUNDING ON JANUARY 31, 1946

The Founders: With Special Reference to Doctors John S. Griffin and Joseph P. Widney.—Seventy-five years ago, on the evening of January 31, 1871, seven physicians resident in Los Angeles met and organized the Los Angeles County Medical Association. Those present were Doctors John S. Griffin, Henry S. Orme, Joseph P. Widney, William F. Edgar, R. T. Hayes, L. L. Dorr, and T. H. Rose. The organization meeting was held in the offices of Doctors Griffin and Widney.

The first president of the Los Angeles County Medical Association was John Strother Griffin, M.D.,* graduate of the University of Pennsylvania in 1837, assistant surgeon in the United States Army, acting in that capacity in the journey starting in Santa Fe, New Mexico, on September 25, 1846, when General Kearney's "Army of the West" made its trek into California by way of San Diego to take possession of California under orders from the United States Government. Doctor Griffin's death in Los Angeles, at age 82, took place in 1898.

Doctor Griffin's associate, Joseph Pomeroy Widney, A.M., LL.D.** received his M.D. degree from Toland Medical School of San Francisco (now University of California), class of 1866. His death occurred on July 4, 1938, at age 97. In 1885, Doctor Widney was the prime mover in the establishment of the College of Medicine of the University of Southern California, becoming president of that University in the financial depression of the nineties, preventing foreclosure on its properties through advancement of his personal securities. Like his associate, he was also an assistant surgeon in the United States Army.

In their time, others of the founders of the Los Angeles County Medical Association also held prominent places in the medical profession.

* * *

Some High-Spots in the Career of the Los Angeles County Medical Association.—Today, the county medical society established in 1871, at a time in California's history, when Los Angeles was grouped with smaller pueblos or municipalities, has developed until now in a county having a population of more than 3,500,000 persons, it has a membership in excess of 3,500 physicians. This membership total makes this county unit one of the six largest county medical societies of the United States. In membership numbers, it is exceeded in number by only seven of the forty constituent state medical associations of the A.M.A.!

Concerning some of its activities, much could be stated of this important county medical society that may be said to be setting a pace for many county and state medical organizations.

In addition to its valuable auditorium and library buildings at Westlake Avenue and Wilshire Boulevard, owned debt free, it possesses vested interests in other income producing property, and in its latest *Bulletin* appear drawings for large additions to its present housing facilities. Its plans and programs for benevolence and postwar funds, group accident coverage, public health lectures, conjoint meetings on medico-legal medicine, radio broadcasts, indoctrination courses for applicants to membership, and its County *Bulletin*,—probably the largest county medical publication in the United States,—are among activities that may be mentioned, to indicate the alertness and up-and-doing qualities of the personnel of the Los Angeles County Medical Association.

* * *

Anniversary Celebration Will be on Thursday Evening, January 31, 1946.—The anniversary celebration of its founding 75 years ago, will be held on the evening of Thursday, January 31, 1946, the ceremonies to be carried on in the Bowl of the Biltmore Hotel. The Association has generously extended to C.M.A. ex-presidents and members of the Council of the California Medical Association an invitation to be guests on this occasion.

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* For other reference to Dr. John S. Griffin, see California and Western Medicine, February, 1944, p. 50.

** References to Dr. Joseph P. Widney in California and Western Medicine, appear in issues of April, 1936, p. 292; May, 1936, p. 396; June, 1937, p. 398; August, 1938, pp. 106 and 161.

On that evening, an historical edition of the *Bulletin* of the Los Angeles County Medical Association of some 200 or more pages, will be distributed.

For this happy occasion, other County Medical Societies and members of the California Medical Association resident in those counties, extend to members of the Los Angeles County Medical Association, felicitations of the day, congratulations on work achieved, and best wishes for the future.

The California Medical Association is proud of its largest county medical unit.

CALIFORNIA MEDICAL ASSOCIATION WILL HOLD ITS 75TH ANNUAL SESSION IN LOS ANGELES, MAY 7-8-9-10, 1946

Streamlined Sessions are of the Past: A Four-Day C.M.A. Session will be held at Los Angeles in 1946.—During the last several years, while World War II was on, it has been necessary to hold two-day, streamlined annual sessions of the California Medical Association.

Absence of many C.M.A. members who were in active military service, additional responsibilities and work that fell on colleagues who continued in civilian practice, over-filled meeting places in major hotels (especially Hotel Del Monte taken over by the Navy), transportation and other complications, all help explain the reason for the recent two-day, instead of the four-day annual sessions that were the custom in prior years.

With World War II now somewhat of the past, the C.M.A. Council in October, optimistically promulgated for the year 1946 a four-day session, to commence on Tuesday, May 7, and to carry through Friday, May 10.

* * *

Wartime Medical Meetings. — Even with World War II drawbacks, many medical meetings have been held by county medical societies and affiliated groups,—of which those under the auspices of the "Wartime Graduate Medical Meeting" committee have been conspicuous examples. The interesting programs of the Wartime Committee have appeared in succeeding issues of the OFFICIAL JOURNAL and even yet should have suggestive value to program committees of county medical societies.

* * *

Possible Essayists are Requested to Cooperate.—This present reference to the C.M.A. annual session to be held in May next at Los Angeles aims to call the attention of component county societies and their members, not only to the meeting—from the standpoint of possible attendance, but to urge in particular, that all members who may be in position to offer possible papers for consideration, should promptly communicate with the C.M.A. Committee on Scientific Work (of which the Association Secretary at 450 Sutter, San Francisco, is chairman), or with the secretary of the scientific section in which the proposed paper would probably be given place. (For list of Section Officers, see in current CALIFORNIA AND WESTERN MEDICINE issue, on adv. page 4.)

* * *

Outline of Program for this Year's 75th Annual Session.—In spite of existing conditions, it is hoped to present in May next, a substantial and up-to-date survey of topics on scientific and organized medicine.

The first meeting on Tuesday morning, May 7, will stress problems related to Organized Medicine of which, in California, there are many.

After which, the major groups on General Medicine and General Surgery will then carry on as in previous years. The remaining eleven scientific sections (Anesthesiology, Dermatology and Syphilology, Eye, Ear, Nose and Throat, Industrial Medicine and Surgery, Neuropsychiatry, Obstetrics and Gynecology, Pathology and Bacteriology, Pediatrics, Public Health, Radiology, and Urology) will each hold one, two or three meetings, depending in part upon the perseverence of the respective Section Officers, and also on the extent to which specialist physicians respond to the appeals of Section Officers for full coöperation.

Commercial or technical exhibits will again be given opportunity for their displays, the income therefrom covering a considerable portion of the convention expense (hotels throughout the nation propose in the future to institute the plan of charging for use of meeting rooms, on basis of a certain sum per day, for each chair required!).

In the Section on General Medicine, the Clinical-Pathological Conference will have suitable place; and panel discussions and joint meetings are under consideration by several sections.

Those very special features—the study groups coöperating with the Cancer Commission. that formerly met the day before the regular session began; namely, Cancer Symposium, Pathologic-Microscopy and Diagnosis, X-ray Diagnosis—will also be in operation, if present plans do not miscarry.

So also as regards programs and conferences of affiliated organizations and bodies—such as California Heart Association, Western Association of Industrial Physicians and Surgeons, California State Board of Public Health,—these. too, plan to hold meetings at which suitable programs will be presented and conferences held.

The Woman's Auxiliary to the California Medical Association will again take up its active work, and make plans for a militant, constructive program in the days ahead.

The C.M.A. Council will hold its daily meetings, and the House of Delegates without doubt, in these troublous times, will have its full quota of resolutions presented not only for consideration, but for policy determination.

Transportation and hotel accommodation difficulties still obtain. In due time, as much information as may be obtainable will be given in regard thereto. Meanwhile, C.M.A. members who may wish to write to Los Angeles hotels will find a limited list in this issue (see page 39).

* * *

The 1946 Annual Session Will be What We Make It.—In conclusion, appeal is made to all members who may be able to participate, to submit titles for scientific papers (this invitation is extended also to military non-members who are stationed in hospital stations of military camps located in California), and to express the hope that not only Los Angeles physicians, but members of other County Societies throughout California will make special effort to be present at the 75th annual session of the California Medical Association.

Make note of the dates of the session, which appear at the top of the front cover of each issue of CALIFORNIA AND WESTERN MEDICINE,—namely, commencing Tuesday, May 7, through Friday, May 10, 1946.

C.P.S. AND VETERANS' ADMINISTRATION

New and Significant Alignments on Medical Care of Veterans.—Recent press dispatches indicate that the medical care of veterans, previously restricted to service in Veterans' Administration hospitals, might be put in operation in certain parts of the United States with addition of "extra"-Veterans' Administration hospital care. There are five VA hospitals at this time in California as follows: three general hospitals located at Palo Alto, San Francisco and Los Angeles; two tuberculosis hospitals operating at Livermore and San Fernando.

The first reference to private practitioner care of Veterans' Administration patients was to a plan instituted in New Jersey. Subsequently, an Associated Press dispatch of December 28, gave information concerning a contract made with Michigan physicians. On the following day, a news item referred to tentative negotiations for medical care to be given along somewhat similar lines, that were being carried on between California Physicians' Service and the Veterans' Administration authorities.

The A.P. item of December 28, dated at Washington, with comment on the Michigan procedure has informative value, and is worthy of perusal:

> HOME TREATMENT PLAN FOR MICHIGAN VETERANS
>
> Washington (*By Associated Press*)—Dec. 28.—Establishing a new policy to relieve its crowded facilities, the Veterans' Administration today announced a contract with Michigan physicians to treat ex-soldiers at home.
>
> The contract is with the Michigan State Medical Society. It provides for its member doctors to treat war veterans whose disabilities are service-connected but do not require hospitalization.
>
> *Another plan nearing final approval would permit veterans to be hospitalized in their own community hospital instead of a Veterans' Administration institution. The Veterans' Administration would pay the bill.*
>
> Major General Paul R. Hawley, acting Surgeon General of the Veterans' Administration, said if the Michigan plan is successful it will be used in other states.
>
> A Veterans' Administration statement said this is the first time a contract has been signed on a statewide basis for care of veterans by private physicians.
>
> *It added, the plan might increase the medical care and hospital space available for veterans with non-service connected disabilities.*
>
> *Federal law requires hospitalization of veterans with non-service connected disabilities only if Veterans' Administration facilities are available.*— San Francisco *Chronicle*, December 29.

* * *

Concerning the New Jersey, Michigan and California Non-profit Agencies.—At the time of this writing, concerning a possible contract with California Physicians' Service, additional information may be gleaned from news items appearing in this issue on pages 45-46.

In the three states referred to, the voluntary non-profit medical service organizations in New Jersey, Michigan and California seemingly have been the instrumental medical groups through which the conferences concerning these new medical care alignments for Veterans' Administration of the Federal Government have been made possible. Therefore, C.M.A. readers may be interested in the following statistical data concerning the three organizations.

* * *

New Jersey,—"Medical-Surgical Plan of New Jersey" with headquarters at Newark in a state having 4,080,485 population, enrolled its first patient in 1942, having on July 1, 1945, a total enrollment in its plan, of 41,732 persons. Its type of benefit is classed as "medical-surgical care, available only to hospital patients."

* * *

Michigan.—"Michigan Medical Service" with headquarters at Detroit in a state having 5,375,195 population, enrolled its first patient in 1940, having on July 1, 1945, a total enrollment in its plan, of 842,057 persons. Its type of benefit is classed as "surgical only."

* * *

California.—"California Physicians' Service" with headquarters at San Francisco in a state having 7,881,694 population, enrolled its first patient in 1939, having on July 1, 1945 a total enrollment in its plan, of 162,000 persons. Its type of benefit is classed as "surgical only" and "medical-surgical, home, office and hospital."

* * *

The figures above given are from the report of the "Hospital Service Plan Commission." John R. Mannix, Chicago, chairman, as given in a November, 1945, brochure, "Non-Profit Medical Service Plans." (Address: 18 E. Division St., Chicago, 10.)

* * *

Announcement of Veterans' Administration Acting Surgeon General—Major General Paul R. Hawley.—During the last year, many criticisms of Veterans' Administration hospitals have appeared in the lay and medical press. On that account it has been reassuring to note the frank-ness and courage of the acting surgeon general of the Veterans' Administration, Major General Paul R. Hawley, indicated in addresses given by him before different medical groups*, and in which he stated his opinion of governmental medicine. From a Chicago dispatch of December 3rd, the following excerpts should be of interest:

> "DON'T CURB DOCTORS," SAYS MEDICAL CHIEF
>
> Chicago, Dec. 3.—(UP.)—Major General Paul R. Hawley, medical director of the Veterans' Administration and Acting Surgeon General, tonight denounced any type of Government control of medicine, asserting the medical field "doesn't need the Government to tell it how" to solve its problems.
>
> General Hawley told the House of Delegates of the American Medical Association, now in session here, that "free and uncontrolled medicine will solve its own problems." . . .
>
> He said the Veterans' Administration has an unprecedented job of treating thousands of veterans with an inadequate number of doctors.
>
> He said private physicians would have to participate on a part time basis in veterans' hospitals and in private practice, receiving standard fees from the Veterans' Administration. . . .

* * *

It is to be hoped that the conferences being held in Washington at the time these comments are penned, will result in arrangements through which the physicians of California may be of increasing aid to returning veterans in need of medical care; while at the same time giving greater opportunity for C.P.S. (California Medical Association's nonprofit voluntary plan for medical care) to demonstrate its capacity for service to citizens.

* * *

Contract Signed Between V. A. and C.P.S.!—On January 8, word was received that the proposed coöperation between Veterans' Administration and California Physicians' Service for medical care of service-contracted disabilities of veterans had been signed.

With more than one million veterans in residence in California, the significance of this arrangement is self-evident. For press item thereon, see in this issue on page 45.

Because CALIFORNIA AND WESTERN MEDICINE is in press, no further comment can be made at this time.

FREE BLOOD PLASMA TO BE DISTRIBUTED —IMPORTANT ANNOUNCEMENT

Value of Blood Plasma Has Been Shown.—The therapeutic value of blood plasma, as a means of saving human lives, has been demonstrated on battlefields and in combat clearing stations, as well as in hospitals, both military and civilian. While the United States was at war, the military personnel had first call and rights for plasma. The story of the blood donor centers is familiar to physicians and civilians alike.

Free Blood Plasma for Use in Private Practice.—Owing to the relative scarcity of plasma available for civilian institutions and for use in private medical practice, it is gratifying to give publicity to the news bulletin appearing below, in which an announcement of free blood plasma is made.

The California State Department of Public Health is formulating plans concerning distribution centers of the plasma. If, prior to the time the current issue of the OFFICIAL JOURNAL goes to press, additional information in regard to distribution is received, the same will be publicized.

The joint news bulletin of the Pacific Area Red Cross and California State Board of Public Health follows:

> Plans for the receipt of 32,277 units of dried blood plasma to be distributed to the public free of charge through local California health departments, hospitals and doctors, were announced on January 2, in a joint statement by the California State Health Department and Pacific Area Red Cross.*
>
> The dried plasma is California's first three months' share in the 1,250,000 units of plasma recently declared surplus by the Army and Navy and returned to the American Red Cross for civilian distribution.
>
> Both Dr. Wilton L. Halverson, California state health director, and Dr. A. E. Hardison, acting medical director of Pacific Area Red Cross, stress the fact that this dried plasma in no way diminishes the need for people to donate blood at the 30 or more civilian blood donor centers now being operated by private organizations and medical groups in California.
>
> "War experience has shown that dried plasma is most effective in about one out of every four cases requiring transfusions, and that whole blood should be used in about 75 per cent of cases," Dr. Halverson said.
>
> The surplus plasma has not yet been received in the Pacific Area. As soon as the first three month's supply of 65,505 units arrives, 19,369 units will be stored in San Francisco as a reserve by the Red Cross. The remaining 46,136 units will be distributed to seven states, Washington, Oregon, Idaho, California, Arizona, Utah and Nevada, on a population basis.
>
> In California, the State Department of Public Health will make the distribution to local agencies through its Division of Laboratories. A distribution plan is being worked out which will insure that as soon as the plasma arrives, hospitals and physicians can obtain the material without delay for patients who need it.**

McClintock's Sign.—From the time that Alfred McClintock received his medical degree from the University of Glasgow to the close of his life, he devoted his efforts to obstetrics. In this field, he assumed an outstanding position, writing numerous valuable works that bear lasting testimony to his ability, observation and experience. The recognition accorded him during life culminated in the attainment of highest professional honors at the time of his death.—Warner's *Calendar of Medical History.*

We should strive, not to live long, but to live rightly.
—Seneca, *Epistulae ad Lucilium*, Epis. xciii, 2.

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* For address of Major General Paul R. Hawley before the House of Delegates of the American Medical Association, at Chicago, on December 3, 1945, see *Journal of the American Medical Association* of December 22, 1945, page 1192.

* For news item concerning plasma distribution, see also in this issue of CALIFORNIA AND WESTERN MEDICINE, on page 56.

** The address of the California State Department of Public Health is 760 Market Street, San Francisco (2), California. The Pacific Area Red Cross has its office in the Civic Auditorium, San Francisco (1), California.

EDITORIAL COMMENT†

CYTOPLASMIC IMPLANTATION

About five years ago, it was shown by Bernheimer and Harrison[1] of Temple University, that there are antigenic differences between morphologically differentiated strains of paramecia. Rabbits immunized against one strain yield antibodies giving precipitin and complement-fixation reactions with homologous strains, with practically no cross-reactions with heterologous strains. Such antisera are specifically toxic. Tested in dilutions as high as 1:800 they often cause a "paralytic phenomenon" or "immobilization reaction" with homologous paramecia. After 2 hour incubation at 28° C, all ciliary action ceases, and the contractile vacuoles and undulating membrane no longer function. Death and disintegration eventually follow.

It was afterwards shown[2] that at least one strain (Paramecium aurelia) is antigenically heterogenous. It can be subdivided into at least four sub-antigenic groups. Bernheimer found no constant relationship between this sub-antigenicity and mating type. Instances were observed in which both members, neither member or only one member of a conjugating pair was immobilized by a given sub-specific antiserum.

In their latest work Harrison and Fowler[3] studied the effects of conjugation between two such antigenically distinct sub-species. Members of each group reacted quickly and extensively to homologous antiserum, but did not react at all to heterologous antiserum. As a result of heterologous conjugation members of each conjugating group acquired the specific antigenicity of the opposite group. This acquired antigenicity persisted for at least one month of active asexual multiplication.

The antigens involved in the conjugation transformation are very largely, if not exclusively cytoplasmic in character. From this and from microscopical evidence Harrison concludes that during the course of conjugation of Paramecium bursaria there is in addition to the well-known nuclear interchange, an extensive interchange of cytoplasm. The resulting cytoplasmic implant apparently multiplies or is multiplied in symbiosis with the new host cell.

Aside from its general biological interest the new theory of cytoplasmic implantation may necessitate a reëxamination of the basic concepts in many fields of theoretical immunology and clinical medicine. The nearest current approach to this phenomenon is in type transformations or capsular ingrafting of pneumococci. The theory suggests the futuristic concept that a similar cytoplasmic conjugation may take place between tissue cells.

W. H. Manwaring,
Stanford University.

REFERENCES

1. Bernheimer, A. W., and Harrison, J. A.: J. Immunol., 39:73, 1940.

2. Bernheimer, A. W., and Harrison, J. A.: J. Immunol., 41:201, 1941.

3. Harrison, J. A., and Fowler, E. H.: Science, 102:377 (Oct. 12, 1945).

E.M.I.C. Will Continue For Some Time After Program Is Declared Ended

With the cessation of the war, it was thought that cases under the Emergency Maternity and Infancy Care (E.M.I.C.) program would soon decrease in California. Since it is now doubtful that a formal declaration of the end of the emergency will soon be made, and since E.M.I.C. will continue for six months after the declaration, it appears that health departments for some time will continue to administer medical and hospital services to wives and infants of servicemen.

Under the policies of eligibility, all cases whose pregnancy occurred at the time the man was in the armed services and prior to the termination of the program will be accepted for care. Infants will also be eligible if the father at any time during the infant's prenatal life was in the armed services prior to the declaration of the end of the emergency. This, in effect, means that the E.M.I.C. program will taper off gradually as men are discharged but that it will continue to be in effect, principally for infant care, for a period from 18 to 21 months after the formal closing of the program which will occur six months after the emergency is declared at an end.

In California there were 3,126 women and 286 infants admitted to E.M.I.C. care during September. A total of 67,636 women and 4,580 infants have been admitted to care since the program was started in California in July, 1943. Expenditures since the start of the program have totaled $5,044,910.63.

Opinion of the Attorney General on Questions Relating to the California Tuberculosis Subsidy

A recent opinion of the Attorney General clarifies questions relating to the awarding of the tuberculosis subsidy, particularly to cities and counties which do not maintain sanatoria. The opinion was given in response to an inquiry from the State Department of Public Health and is quoted below.

"Sections of the Health and Safety Code material to this opinion are as follows:

" '3300. Each city, county, or group of counties may establish and maintain a tuberculosis ward or hospital for the treatment of persons suffering from tuberculosis. Each city, county or group of counties that establishes and maintains a tuberculosis ward or hospital shall receive from the State the sum of seven dollars ($7) per week for each person suffering from tuberculosis, cared for therein at public expense (*or cared for in private hospitals or sanatoriums under contract with the county,*) who is unable to pay for his support and who has no relative legally liable and financially able to pay for his support and who has been a bona fide resident of the State for one year; except that the city, county, or group of counties is not entitled to receive this State aid unless the tuberculosis ward, sanatorium or hospital conforms to the regulations of and is approved by the Bureau of Tuberculosis.' ". . .

Los Angeles Center Conducts Research

The Los Angeles Rapid Treatment Center has been selected by the United States Public Health Service as one of the institutions to conduct research in the treatment of neurosyphilis with penicillin and fever therapy.

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† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

Scientific and General

SICKNESS INSURANCE*

IN RELATION TO CALIFORNIA MEDICAL ASSOCIATION

John Cline, M.D.
San Francisco

SINCE he first appeared on the earth, man has engaged in a relentless effort to improve his lot. As his condition has improved, he has striven more and more to attain perfection. This restless quest for something he can never fully achieve is, I believe, one of the main driving forces of civilization. The voluntary effort of the individual man, alone or in concert with others, has been productive of most of the progress of the world. This applies with equal force in the fields of Science, Technology, Industry, Agriculture, the Professions and Politics. In the political field, it was the desire for freedom and the respect for individual rights of the common man which created democracy and which have preserved it in a number of the countries of the world.

Had we been born secure in health, in income, in freedom from want and worry, most of us would have been deprived of the great motivating influence which made it possible for free industry and free labor to have met the tremendous production demands of the war just recently ended.

If the day ever arrives when mankind achieves complete security, human progress will slow down or stop from that day forward. We shall cease to be a virile, progressive people and will probably degenerate because of the very fact of assured soft living.

You may consider this a strange beginning for a talk to a social security conference, but it is my opinion that the most dangerous delusion of our time is the widespread conviction that we can achieve social security by enacting legislation and turning the problem over to Government. You and I desire security, but we desire the security which we ourselves have had a part in creating. We do not wish Government to replace our initiative, desires and ambitions with a gratuity of limited perspective, such as the so-called social planners would thrust upon us. Like most of you, I wish to continue chasing the pot of gold at the end of the rainbow, and I do not expect Government to find it for me.

Now I am ready to discuss Health Insurance.

"HEALTH INSURANCE"—SICKNESS INSURANCE

At the outset, let me make several facts perfectly clear. In actuality, the term "Health Insurance" is a misnomer. It should more properly be called "sickness insurance." Its principal value lies in the application of the insurance principle to prevent the economic ravages of serious illness. It does not possess the golden attributes which the advocates of compulsory Health Insurance would have you believe.

Health Insurance has been painted in glowing terms as a means by which the incidence of disease could be greatly reduced. The preventive medicine feature has been repeatedly stressed. This is purely a manifestation of ignorance of the problem involved, which is common experience, when well meaning, but misguided persons, enter a field with which they are not familiar. The facts clearly refute any such contention.

Preventive medicine falls largely in the sphere of Public Health. Viewing the problem as a whole, comparatively little preventive medicine is, or can be, practiced by the individual physician. The primary bases for good health are good heredity, proper and adequate food and shelter, good habits and education. The draft statistics adequately demonstrate this to be the case.

Health Insurance is not a cure-all. It is merely a sound way of protecting your family's financial resources from being drained away in unpredictable periods of illness. It is a form of insurance against economic catastrophe. It will not prevent the development of a serious disease or the necessity for an operation, but it will permit you to undertake this treatment or that operation without making destructive demands upon your savings or assets.

"HEALTH INSURANCE" AND THE GOVERNMENT

Let me make one additional fundamental observation. There is nothing that Government can do for you in the field of Health Insurance which you cannot do for yourselves and do better and at less cost. This statement does not apply only to those assembled here today. It is equally true of all the people in California, except indigents, and all the people in the United States with the same exception. The fullest advantages of Health Insurance cannot be attained by just compelling people to pay into a fund. If compulsion were to be employed, it would also be necessary to compel people to go to a doctor and then unqualifiedly follow his advice. Certainly this variety of compulsion would be repulsive even to the ardent advocates of compulsory health insurance.

Now let us talk about the practicalities of the California situation. In the last legislature, a number of proposals for compulsory Health Insurance were introduced. The motives behind the introduction of the various bills may have differed, but all had the objective of solving a problem which we recognize to exist. That problem is the wide distribution of the costs of medical care through application of the insurance principle. The defects of the efforts at solution of this problem were apparent to all of you.

DEVELOPMENT OF INSURANCE PRINCIPLE

Not long ago, one of my friends in the life insurance business, told me that it took a hundred years to bring life insurance to its present stature. Now a majority of our people provides protection for its families against the tragic consequences of death. Today, every provident man carries life insurance for his family, and I believe this to be one of the finest social advances in the history of our country. This has been brought about, not as a result of governmental compulsion, but rather through the medium of education and private enterprise.

Private enterprise and the voluntary system have already accomplished the insurance of medical costs for a large segment of the population of California. The figures compiled by your own organization, earlier this year, estimated that some variety of coverage for hospital, medical care, or both, had been provided to about one million five hundred thousand people.

PRESENT PLANS OF CALIFORNIA MEDICAL ASSOCIATION

The California Medical Association is about to embark upon an intensive effort to accomplish in the next two years what has been achieved in the field of life insurance during its period of existence. The medical profession realizes that it cannot do the job alone. If we are to succeed, we need the help and active coöperation of business and civic organizations, of the press, of leaders in every walk of life. We need a coördinated campaign by every insurance company in the business—with the private insurance carriers, the Blue Cross Organizations, California Physicians' Service and all other health insurance and service systems working together to sell the principle of voluntary health insurance to the people of California and then sell them coverage.

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* Address given at Annual Meeting of California State Chamber of Commerce, in Los Angeles, November 29-30, 1945.

Health Insurance in one form or another is coming in California and throughout the United States. It is coming in a matter of a very few years. That is my considered opinion, and I believe that it reflects the consensus of opinion among those who have studied this problem. The recent interest of the Federal Administration in Health Insurance will unquestionably give impetus to its development.

VOLUNTARY SICKNESS INSURANCE—GOVERNMENTAL COMPULSORY INSURANCE

The only question, and this is a vital question, is whether it is coming on a voluntary basis as a new strong unit of our private enterprise system or whether it is coming on a compulsory basis with Government at the controls.

I believe you will agree that we already have too many Government controls, far too many. We all recognize, I am sure, the urgent need of getting rid of war time controls, rather than adding to them. I can assure you that the doctors of California will fight to the last ditch against bureaucratic political control of their profession, not just because they want to remain in the private practice of Medicine, but because the quality of medical care deteriorates when State Medicine comes in. However one may dress it or refurbish it, compulsory health insurance in any one of its proposed forms is State controlled State Medicine. The effort of the politicians to avoid the term "Socialization of Medicine," when that is exactly what they are trying to accomplish, is purely political window dressing.

The members of the California Medical Association are fully conscious of their responsibility and they intend to give heavily, both of their funds and their time and energy to develop voluntary health insurance coverage for the people of California.

COÖPERATION IS NEEDED

As I said earlier, we will be unable to accomplish this alone. We need your help. At this point, I wish to make grateful acknowledgment of the splendid help which the State Chamber of Commerce and other business and civic groups gave us during the fight against compulsory health insurance in the recent Legislature. We could not have won that fight without your help, and we are deeply appreciative. We realize, and I am certain you realize, that if Medicine should be socialized, it is but one step in the general development of socialization of all varieties of endeavor. There is now a greater appreciation on the part of the medical profession of your problems, as there is on the part of business of our problems. You will find the medical profession quick to respond when any other branch of our private enterprise system comes under attack.

CALIFORNIA PHYSICIANS' SERVICE

Next year the California Medical Association is planning to launch a vigorous advertising and sales campaign to develop California Physicians' Service. The object is to enroll tens of thousands of new members in this health insurance plan. As desirous as we are of furthering California Physicians' Service, we certainly do not wish all the business.

We hope that every private insurance carrier in the health insurance field will double its advertising and sales budget next year and will write more policies in one year than it has written in the past ten years.

We hope that the Blue Cross Plans and every other sound hospital or medical system will get into the campaign to make California health insurance conscious, and we hope that their memberships will grow enormously.

CAMPAIGN FOR VOLUNTARY SICKNESS INSURANCE

A large portion of the money which the California Medical Association has allocated for next year's campaign will be spent in an effort to sell voluntary health insurance in principle, rather than merely to build our own California Physicians' Service.

We intend to conduct an intensive newspaper and magazine advertising campaign to build up not only California Physicians' Service but all voluntary health systems. We will have radio advertising keyed to the same purpose. We will have an aggressive publicity campaign in the newspapers, magazines and trade publications, all designed to make California health insurance conscious and to open the doors for salesmen selling such coverage.

We intend to organize a public speaking campaign to cover civic groups, service clubs, women's organizations, farm and veterans groups, and every speaker will be trying to convert people to providing for the cost of illness on a regular budget basis during periods of good health and stable earning power.

We will have contact men in the field calling on the heads of major businesses and industries, labor unions and other employee groups to educate both management and workers to the need for prepaid medical care.

We intend to take leadership in setting up an overall organization, probably to be known as the California Coordinating Committee for Voluntary Health Insurance and representing more than one hundred State organizations, which are already on record against compulsory health insurance and which should be tied into a joint campaign for voluntary coverage.

In addition to civic organizations, all private insurance companies which handle health insurance, as well as all service plans, will be asked to participate in this organization.

The purpose of this coördinating committee will not be to sell any specific health insurance plan, but it will issue literature with data on all sound service and insurance plans with the object of selling the voluntary principle.

In short, the California Medical Association intends to furnish the money and the motive power for a whirlwind campaign to insure the budgets of Californians against the ravages of illness and accident. We feel it is imperative that a majority of our citizens be covered by one of the voluntary plans, and if at the end of 1946, the private insurance carriers have the bulk of the business, we shall be entirely satisfied.

MEDICAL PROFESSION'S OBJECTIVES

We desire primarily to make medical care available to as many of our people as possible on a basis they can afford and to assure them when they are ill, they can still call their own doctor and expect to receive from him the same kind of personal attention he has previously provided for them.

We don't want them to be in the position of having to clear with some bureau in Sacramento or Washington before being told how they can obtain care for a sick child or a dangerously ill mother. We want the physician of his choice to be free and unhampered in his care of the injured or ill person. We know that State medicine is bad medicine, and we want no part of it in California.

LIMITATIONS OF GOVERNMENT AID

Let me revert briefly to my original premise, the dangerous delusion that Government in some mysterious way can give us a blanket guarantee of security against old age, unemployment and all the other problems that mankind is called upon to confront.

When Government seeks to guarantee security, it does so at the price of liberty. Let us not be deceived about that.

In his brilliant book, "The Road to Serfdom" Frederich Hayek makes an excellent summary of the sequence of events when he says:

"The slave state always starts out as a 'welfare state.' It promises freedom from want, worry—as many freedoms as you wish, except freedom from the State itself!"

For many years past, we have observed a continuous growth in Government, both in scope and in the numbers of people involved. Instead of increasing the number of bureaus and employees of Government, we should reduce them. The addition of a large bureau to carry out a compulsory health insurance plan would add greatly to the operating expense of the Government. Such a system would have to be supported by taxes. There is no way of calculating its cost. The ironic aspect of this would be that in return for a tremendously increased burden of taxation, the people would be provided with medical care of a distinctly inferior quality. They would be buying a third rate product at a premium price in dollars and at the sacrifice of another segment of freedom.

The physicians of California wish to serve the people of this State without the interference of onerous rules and regulations and control by bureaucrats and medically uneducated petty clerks.

That, simply stated, is the story. Thank you for the opportunity of speaking to you this morning, and let me earnestly ask you to get behind our campaign for voluntary health insurance.

490 Post Street.

THE ARMY DOCTOR*

Colonel Russel V. Lee, M.C.
MEDICAL CORPS, ARMY OF THE UNITED STATES
Palo Alto

ANY proper appraisal of the rôle of the Army doctor entails an appraisal of the Medical Department of the Army in which the individual doctor was merely one unit in 50,000. A proper appraisal of the accomplishments of the Medical Department in this war demands some consideration of the effort in other Wars and in other armies. In all candor, it must be said that until World War I, in spite of numerous individual examples of devotion to duty, heroism, and brilliant medical accomplishments, the work of the Army Medical Department was something less than distinguished. Distinguished individuals there were indeed. One need mention only such names as Letterman; who devised and put into operation ambulance evacuation; Hammond, the brilliant surgeon-general of the Civil War; Sternberg, who was really the father of bacteriology in this country; Reed and Lazear, who so heroically demonstrated the mosquito borne character of yellow fever; Gorgas, whose application of proper sanitary measures made possible the construction of the Panama Canal, to prove that the Army doctor in the past has attained a high place in medical circles. That this was done in spite of congressional apathy, opposition from the line, and a general inadequacy of equipment and funds, is all the more commendable. For it is a fact that until World War I, the Medical Department never had proper support or importance.

SET-UP OF MEDICAL CORPS IN FORMER WARS

In the Revolution, regimental surgeons were supplied by the colony that raised the levy, and they held first loyalty to the colony. There was a sharp distribution and bitter rivalry between so-called troop surgeons and hospital surgeons, and nothing like an over all medical organization. Nor did the war of 1812 add anything to the development of a real service.

The medical experiences of the Mexican War were dreadful. The supply of surgeons authorized was inadequate, there were no enlisted personnel attached to the Medical Department. Dependence was had on the band, on the cooks, and on the hostlers, for the care of the wounded. True, little was known about sanitation and hygiene but even the emperical knowledge which did exist was not applied. As a result of these deficiencies, plus a campaign in an unhealthy tropical climate, General Scott actually lost one-third of his troops from disease. The recommendation of the Medical Department that the port of Veracruz be avoided as a bivouac area was disregarded. As a result, yellow fever losses were heavy and the disease was introduced into several port areas in the United States. Neither this experience, nor the lessons of the Crimean War, in which military medicine made some notable advances, had any influence here and the Civil War found us little better off for a Medical Department.

However, during the course of the Civil War, Letterman, only 38 years old, developed the system of ambulance evacuation of wounded, set up something like adequate field hospitals, and with the support of his superior, General Hammond, made some progress in getting medical personnel assigned. However, the army reverted to a small force widely scattered among Indian fighting posts, and the progress made was largely lost.

In the 33 year interval between the Civil and Spanish War, the Army Medical School proposed in 1862 by Surgeon General Hammond, was established in 1893. But when the Spanish War began we had about 190 doctors, a total of a 100 hospital stewards authorized, no medical supply system, no medical reserve corps, no mechanism for securing physicians, no real table of organization for a medical establishment of any level. The unfortunate medical experiences of the Army in that war are within the memories of some of you. The killed and wounded were only few, the deaths from disease were appalling. The Dodge Commission appointed by President McKinley to investigate the situation made a number of recommendations which the very capable Surgeon General O'Reily put into effect, together with a number of good ideas of his own. Congress in 1908 passed a law which set up allowances for medical personnel and more important for the future provided for the establishment of the Medical Reserve Corps. Enlistments in the regular establishment were hard to get but, led by some of the most distinguished medical men in the country, the Medical Reserve Corps was built up sufficiently to absorb the first shock of demands for doctors for World War I. We had the years from 1914-1916 to get ready, and much was done. The volunteer committee in medical preparedness offered to make a study and classify available doctors and this was excepted. Dr. Fredrick Martin was appointed to the council on National Defense and he formed a strong group including the Surgeon Generals of the Army and the Navy and leading civilian physicians as well.

The type and the adequacy of medical care rendered in World War I was infinitely better than the Army had ever seen before. The only serious disease situation was occasioned by the world wide pondemic of influenza, for which there was no real treatment and incomplete knowledge of prevention. The conquest of lockjaw and of typhoid fever and dysentery were notable advances in military medicine. During this period, however, the Medical Department was put under the service of supply and this has been continued by the present situation in which the Surgeon General is in the Army Service Forces. This arrangement has made for certain difficulties which will be touched upon later.

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* This article has been released for publication by the Review Branch, War Department of Public Relations. The opinions and views set forth in this article are those of the writer and are not to be considered as reflecting the policies of the War Department, or the military service at large.

From the Preventive Medicine Branch, Office of the Air Surgeon.

MEDICAL CORPS IN WORLD WAR II

World War II found us in much better condition medically than we had ever been before. The Medical Department as a whole and the Surgeon General's Office in particular had been well organized. Branches had been established for all the main divisions of medical activity. An exceptionally distinguished group of medical men had been appointed as special consultants to the Secretary of War. Commissions to deal with certain special diseases, such as the Typhus Commission, etc., were established under highly trained men with special knowledge of their subject. Tables of organization for every level had been drawn up. Manuals had been written covering many technical phrases of military medicine. There was a fairly important Medical Reserve Corps, particularly a number of units assigned as field or general hospital teams by various medical institutions, and these were ready for immediate call. More important than anything else there was in existence a large body of highly trained doctors, the product of the magnificent advances in medical education which have been achieved in the past twenty-five years. These young well-trained doctors have provided the soldier with personnel medical care of a quality that soldiers have never received before, and for the first time they have been available in adequate numbers. To use an army expression the medical department has been "fat."

Those medical men who were attached to, National Guard Organizations came in automatically when the guard was mobilized before hostilities began. Then as the army grew the Reserve Corps was called into active service.

PROCUREMENT AND ASSIGNMENT SERVICE OF WORLD WAR II

But by far the greatest number of doctors came in through a new and unique device known as Procurement and Assignment. Originally an unofficial voluntary organization to assist in the selection of doctors, it ultimately was made official as a component of the War Manpower Commission. Procurement and Assignment consisted of committees organized in a county basis with state-wide supervision. These boards reviewed the qualifications of physicians and the needs of the community and certified certain doctors as essential. Those not so listed as essential were invited to apply for commissions from the Army or the Navy. If a doctor declined to do this he was certified to his local draft board and in a very few instances was drafted as a private in the Army. Some of these were subsequently commissioned. Some served through the war as enlisted men. I think it can be said that in general Procurement and Assignment did a magnificent job. The pressures under which these boards labored were truly terrific, the power they held was very great, with correspondingly great responsibility. If they sent away Dr. A while declaring Dr. B essential it was certain that Dr. B, in a community depleted of doctors, would make a great deal of money while A got along as best he could on army pay. They could wreck a medical school by sending away key teaching personnel, could cripple important research by removing vital doctors from an organization. Part of the activity consisted in keeping doctors at home who were anxious to enlist. There were bound to be complaints about such a system. In the army one hears, not infrequently, contempt expressed for this or that individual who had himself declared essential, coupled with the implication of undue influence being brought to bear upon the boards. But in the absence of a foresighted scientific classification of available medical men for military service this extemporized device has worked well.

MILITARY RANK GRANTED TO MEDICAL CORPS PERSONNEL

The rank your doctor received depended upon his age and his degree of competance. Up to the age of 37 he was commissioned as a first lieutenant if he had presented no evidence of qualification as a specialist, if qualified as a specialist he received the rank of captain. Above 36, specialists were made majors, others captains. Certain highly qualified individuals were commissioned as lieutenant colonels and a very few as full colonels. Promotions never satisfied anyone completely. Regular army officers of whom there were relatively few fared rather better than the reserves.

This has not made some AUS* men particularly happy. There were never enough T/O vacancies to give rank to all who deserved it. There were many examples of unfortunate individuals who by being transferred or for other reasons lost out on promotions obviously deserved and earned. The matter of prestige in this matter became exceedingly important to many medical men. There were a few recurring situations in regard to promotion which caused gripes. Mature medical men of judgment and experience and of some importance at home were burned up to find a youngster in the line or a young pilot with the rank of lieutenant colonel while they were still captains. The generality that "paper work," i.e., administrative positions carried the rank which were resented by many who believed that professional ability should have been the criterion by which medical officers were ranked. It was quite universally believed that considering their educational backgrounds in comparison to line officers, that the whole scale of rank allowed to the medical department was too low. One hears the proposal, frequently put forward, that rank as such, because it signified chain of command, might well be abolished for medical officers. That the pay go with the position held, that they all be on the same level as far as rank was concerned and designated as "doctor."

MILITARY TRAINING OF MEDICAL PERSONNEL

Most of the doctors who came in were sent first to an officers training school. Carlisle Barracks has been set up as the school for medical officers, and the type of instruction given there was generally regarded as excellent. In the tremendous rush of new officers, early in the war, emergency schools were set up in various places under less experienced instructors, and with consequently less thorough instructions. Some questioned the necessity of the doctor being taught all the administrative detail which was given in these schools, maintained that a trained M.D. was wasted in any case in administration, that all the logistics so painfully learned had no bearing on his medical activities and were soon obsolete anyway. Some units went through long, long months of military training before they ever saw a patient. They complained.

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* Ed. Note. AUS—"Army of the United States"—Selective Service and Volunteers; U.S.A.—"United States Army"—Regular Army Medical Corps.

PROFESSIONAL OPPORTUNITIES IN THE MILITARY ESTABLISHMENT

For some army doctors, the war was an educational opportunity. If he were fortunate enough to be assigned to a large busy hospital he might see such numbers of patients with a given condition, as would have taken a life time of ordinary practice. As a youngster he would frequently find himself under a board specialist, who had also been a professor in a medical school, and who could teach the junior officer a great many things. The complaints so common in the last war of misassignment was much less frequently heard in this war. Because of the policy at most posts of caring for the dependent personnel even obstetrician and pediatrician had an opportunity to practice their specialties. There were exceptions, but due to the careful and painstaking effort to find a man's aptitude, such bad assignments were not common. Most doctors found themselves at some post or station in the United States at first. As troops were trained certain ones were chosen from the pools at the various stations and assigned to the troops directly as battalion and regimental surgeons. In the Air Corps, they were sent to the school of aviation medicine and then assigned to squadron flight surgeons. Professionally these men frequently had a pretty thin time of it. The instance of illness was low, and all the serious cases were immediately sent to a hospital. So the doctor frequently spent long periods with very little to do almost no real medicine or surgery, a good deal of dry paper work. He was often unhappy. Some attempt later was made to work out some kind of rotation so that the battalion, dispensary or squadron surgeon had his turn in the hospital with patients. It never got very far, unfortunately, and as a result a good many young men lost rather than gained in professional skill.

HOSPITAL FACILITIES

The numbered general hospitals, station hospitals and evacuation hospitals that were set up and sent overseas were pretty well stuffed. Until the supply ran out, they were usually commanded by a regular army officer and the chief department headed by board specialists or men with equally high professional attainment. In activating these hospitals the machinery strained by the great overload, frequently showed the lack of lubrication. At times medical officers would be urgently demanded from a busy station hospital for inclusion in a new numbered general hospital, and then would have many weeks of complete inactivity while the unit was being put together, trained, moved from place to place, or set at a port of embarkation. These hospitals overseas were prepared to furnish first class medical and surgical care and did just that when they were utilized. The necessity of preparing for the worst that might happen in the way of casualties impelled the activation of more hospitals in certain areas than were actually needed. The most common complaint heard as one visited these hospitals in the field was that of not enuogh to do. Even on this state of affairs in a given theater was known to the surgeon general, the relationship he bore to the theater precluded his putting up these hospitals at will and moving them to a busier area. This gave rise, naturally, to a good deal of dissatisfaction and complaint on the part of highly trained men who having left busy practices found themselves idle. The position of the Surgeon General's Office, not being in a staff fund, being set up as referred to before in the Service of Supply and furthermore the position of the Medical Department always underline command frequently prevented logical readjustments of such unhappy situations.

EXPERIENCES OF OVERSEAS PERSONNEL

The doctor overseas with troops in training waiting for action with air groups or waiting for squadrons, frequently had a life rather far removed from the actual practice of medicine. Some time on sick call, some time on sanitary inspection of the camp area, some time making out reports, and a great deal of time with nothing to do, was common. In action there might be periods of intense activity, long hours, extreme fatigue and not uncommonly, great danger. A good many of these younger men were casualties. This was really the hardest lot of all. If they were good, and they generally were, their commanding officer would not let them go. There were slight chances for promotion, very little opportunity for medical advancement and some real danger. They should be given every chance to get back to active medical training again as soon as possible. They sometime showed their own kind of non-occupational fatigue. One captain, encountered, dully staring into space on a quiet out of the way station was asked, "How long have you been here." "Oh," he said, "I don't know and they won't tell me!"

MEDICAL ACHIEVEMENTS IN WORLD WAR II

The record of the achievement of the Medical Department in this war is truly a proud one, and it was not accidental but was the result of intelligent application of known discoveries and preventive medicine and of skillful bedside medicine and surgical care. The instance of venereal disease was kept low and in spite of an unparalleled breakdown in social barriers. There were no serious epidemic diseases in the continental United States. Malaria got out of hand briefly when we first went into the Pacific. Two factors contributed to this. First, the nature of the fighting precluded taking proper malaria precaution. Then, second, it was some time before the general and the colonels would listen to the doctors and put in the proper malaria control program. After a year even this disease, fantastically difficult to control under conditions of jungle warfare, was brought down to the trivial point so far as affecting the effective raid of troops. Plasma, the sulfomanoids, penicillin, and extremely competent individual care given casualties cut the mortality to an incredibly low point. If a man could be brought in alive he had a very fine chance of survival, regardless of the extent of his wounds. There was no lockjaw, no typhoid, practically no smallpox, no typhus, no plague, all diseases that have destroyed armies in the past. The development of air evacuation of wounded which reached remarkable numbers before the end of the war contributed greatly to morale, saving of life, and suffering. It was possible to bring patients from the Solomons, for instance, to San Francisco in two days, and thousands were so carried. The distribution of DDT by aircraft promises to change the social geography of the world in eliminating insect borne diseases. This has been directly the result of investigations carried on by the Medical Department of the Army Air Forces. Together with collaboration with the insect control committee in the Surgeon Generals Office, and the Department of Agriculture and Navy. It is not too much to say that the health of the whole country and of the world will be measurably improved as a result of the experiences and discoveries gained by the Medical Department of the Army in this war.

I have never heard of the same complaint of incompetent or mistaken care on any noticeable degree. The very mortality rate of soldiers as compared to civilians with the same disease speaks for that. The mortality rate of soldiers has been incredibly low with such diseases as pneumonia, meningitis, and other such conditions which have always carried a high mortality of civilian life. This has been due to the careful indoctrination of the individual medical officer in standards and proper procedures as to the very high quality of doctors that were recruited for this Army.

CONCERNING DEFICIENCIES IN MEDICAL ORGANIZATION

Well, one can justifiably point with pride to all of these achievements, it is no more than fair to point out some of the deficiencies in the medical organization in this war and to suggest means that can be improved in the next war.

The injustices and the delays and confusions of enlistments and assignments of commissions, were many. It would seem wise if we are faced with such a situation again and in any case, that all the available medical officers in the quiet times of peace, be classified as to their availabilities, and medical service. That they know in advance the order in which they are likely to be called, and the capacity in which they are likely to serve. In this way, the communities can adjust themselves if they find that they are overstaffed with a group of young doctors that are liable to military service, and the proper cushioning of the effect of such calls can be achieved. In this war there were many communities that were left practically depleted, either because their doctors were of an age group that were liable for military service, or because they rushed off in a body and volunteered, before the Procurement and Assignment was set up to prevent such occurrences. There was also a notable difference the way in which certain communities responded and some differences the way Procurement and Assignment boards functioned in various places. It is only fair to say that the record of San Francisco, in this regard, was very good. It contributed more than its average share of doctors to the armed forces. By the proper advance, scientific classification for doctors in regard to their military availability, would have obveated all this doubt and confusion. In addition it would have meant that the doctor would have made his own plans much more intelligently and would have avoided many of the hardships that have resulted from this war. But young doctors oftentimes deeply in debt were called into the armed services. They had to abandon their insurance programs, frequently lost their houses, by the time they had moved their families two or three times, were borrowing money from the bank again. Had they anticipated the possibility of military service, knowing how long it might have taken, this could have been obveated.

Another improvement that seems possible is in the physical standards of induction for doctors. A great many doctors who came up for commissions were disqualified because of trivial physical defects. These same doctors went back home and worked from 10 to 14 hours a day and made a great deal of money while their other brothers in the Army were serving with much less arduous duties and for much less remuneration. It was difficult for the Army doctors to understand why these physically disqualified individuals were able to work so hard at home.

A different standard of physical qualifications for doctors taking into account the fact that he is not likely to be called upon to hurl a grenade, make long forced marches, or carry a gun or a bayonet, might be in order. Also some system of rotation, whereby after serving a certain length of time in the Army, a doctor could go home and his place can be taken by a man who had been at home living under more or less normal conditions would have spared many injustices and saved lots of outraged feelings. It was quite obvious that many of the doctors who were left at home on allegedly physically grounds could have served perfectly well had they been called into active service.

"DOCTOR SHORTAGES" IN MILITARY AND CIVILIAN GROUPS

There has been a great deal of discussion raised as to whether the total number of doctors who have been taken into the armed forces was excessive. There seems to be indications that this whole matter of military requirements be subject to careful study. Yet, it is not unlikely that in due to the possibilities of air transport, air evacuation, and air supply of hospitals, that the number of doctors called upon could have been much less. Improvement in organizational efficiency which control the movements of hospitals and individual physicians could have also saved a great deal of time of idle waiting in pools and redistribution centers. The impact of war and the tremendous expansion of the Medical Department for a time overwhelmed the office machinery. In the beginning the commissions were oftentimes held up for several months while the paper work was finished, during the very period while the Army was urging doctors to enlist. Doctors found it difficult to understand after receiving such urgent appeals why it was that three or four months elapsed after they applied before they received commissions. It was simply that the mechanism did not exist for handling the tremendous amount of paper work that was entailed. The old matter of paper work in the Army and the actual operational side has been talked about a great deal. A certain amount of this is inevitable and a good deal of it has been eliminated during this war. There still seems to be too much and a study of the possibilities of more efficient reporting and record keeping, etc., would seem to be in order, in order to avoid waste of professional time in strictly non-professional matters. A system of rotation in the services, whereby a man who spends a certain amount of time in the field could then be given assignments in hospitals where there are opportunities for learning in the actual practice of medicine, should be more carefully worked out. This would leave the doctors who have served in the Army better satisfied with the type of organization in which they find themselves.

RESEARCH ACTIVITIES

The program of research, and investigation upon which the Army has embarked should not be abandoned in peacetime. The Corps of Liaison, with the OSRD University, and other agencies which have resulted in such prompt application of epic making discoveries has occurred in the case of penicillin and other preventive medical discoveries as well, should be continued. It is from such work as this that the health of our troops in the future will depend.

ON RETURN TO CIVILIAN PRACTICE

Your Army doctor will shortly be coming home. You will find that he will fall into several catagories. First there is the youngster who has come direct from medical school to the Army with no opportunity of practice and very little opportunity for advance training. These boys will want and will deserve to have a period of specialized training in the hospital. Medical schools and other institutions should make places for them to see that they can get the specialized training in medicine and surgery which their immediate predecessors had and which was so largely responsible for the magnificent care the soldiers received.

A somewhat older group of these young doctors returning who have already had their specialized training and had just begun to practice, represent a somewhat different problem. Frequently their financial situation is none too good. Often they had started practices, were doing very well and had embarked upon a standard of living which cannot be maintained on army income. These men will frequently require some sort of financial assistance until they can get fairly established again. Their insurance programs have been seriously interferred with, their regular payments on houses, etc., have been stopped.

It is hoped that during a period of postwar prosperity, these men will be given an opportunity to recoup some of their losses. They truly made a great contribution to military medicine.

There is another older group who have had many years of practice and have served in the Army in various specialized capacities. These men frequently show a complete change of attitude toward their practices. Often times they were men who worked tremendously hard for very long hours every day and now find themselves quite disinclined to go back to such a type of life. You will find these men more anxious to make some sort of arrangement that limits their time to a more reasonable period than that to which they were exposed before the war.

ON READJUSTMENTS IN CIVIL PRACTICE

The medical officer is no more amenable to regimentation as a result of his Army experience as he was before, perhaps less so. But he has seen the possibility of rendering good medical care by a species of group practice. The soldier has no pre-choice of position and actually it is well demonstrated in Army practice that it doesn't make a great difference, as it is so frequently stressed in its favor. The soldier takes whatever doctor is assigned to him. The assistant takes care of him, and the result so far as mortality and nobility are concerned speaks for themselves.

I think that it will result in the Army doctor on his return, being much more interested in the group practice in medicine, then he was before. The tendency to ally himself with other individuals who represent various specialties and practice in a way somewhat like he practiced in the Army, I think, will be seen increasingly in the country. The Army doctor needs some readjusting to normal peacetime life just as does the civil population, just as does the veteran in other categories. In general, his contribution to his country's welfare has been very great. Unselfishly and exceedingly capably done. There will be instances where he will be considerably put out by the records of his brother physicians who have stayed home. An understanding attitude will be necessary between them to prevent there arising a group of service doctors as distinguished from those who did not serve. This would seem to be unfortunate in the light of the practice of medicine for the future.

You will find in general when your Army doctor comes back, he will be the same man he was before, however, eager to serve, anxious to get along, and very happy never to leave his home town again.

Palo Alto Clinic, 300 Homer Avenue.

COMPARATIVE PATHOLOGY OF NATIVE CHINESE AND AMERICANS: SOME OBSERVATIONS*

CHARLES L. DALE, M. D.
Los Angeles

THE present global war has stimulated much interest in regional or geographic pathology. Observations, based on seven hundred autopsies performed in the American Hospital for Chinese Refugees, Shanghai, China, together with a large amount of surgical pathology in several hospitals for Chinese, and a review of much general clinical material in the Chinese population of the same city, revealed a striking contrast in frequency of various pathological conditions, between that population and the population of the United States.

Tuberculosis was the outstanding disease entity. There was very little hospitalization for pulmonary tuberculous patients; therefore post mortem material was minimal. However, in all hospitals which served the geenral Chinese public, the most frequent tissue diagnosis, even on surgical material, was tuberculosis. These specimens included lesions of almost every part of the body and were usually complications of the primary tuberculous complex.

The *acute infectious diseases of childhood* were comparatively infrequent considering the crowded war conditions. However, the acute enteric diseases, chiefly typhoid fever, bacillary dysentery, and cholera were serious causes of morbidity and mortality.

CLINICAL MATERIAL IN SHANGHAI AREA

A survey of the clinical material in the Shanghai area revealed that *amebic dysentery* was relatively infrequent. Routine stool analyses in several laboratories showed an incidence of ameba histolylica below 5 per cent. In seven hundred autopsies on Chinese refugees, twelve showed amebic colitis. Three of these had perforations of the colon and three had abscesses in the liver.

Typhus fever in Shanghai was interesting. In 1937, following the outbreak of the Sino-Japanese incident, a few sporadic cases were seen. From 1937 to 1942 the number of cases about doubled each year. However, in 1943, when we expected a correspondingly serious epidemic, for some unexplained reason there was hardly a case. Mortality among the Chinese, infected with typhus fever was below two per cent, while Europeans and Americans presented a forty per cent death rate when attacked by this disease.

Benign and malignant tertian malaria was a common cause of morbidity. In the surgical pathology material, malarial spleens were frequently seen, having been removed because of lacerations and rupture due to trauma. There was a rule in the Shainghai police force that an offender, who offered resistance, should not be struck below the neck, because of the frequency of ruptured malarial spleens by even quite minor blows.

In all types of pathological material, and clinically, the complications of the venereal diseases were seen. Gonorrheal epididymitis was relatively frequent, but joint complications appeared to be rare. Syphilitic aortitis and aneurisms were seen clinically and at post mortem. Sudden death, even among the coolies, was occasionally due to closure of the coronary ostia. Lymphopathia venereum was common, buboes were frequent, and, while rectal strictures occurred, I was particularly impressed with the large number of granulomatous masses in and about the rectum and anus, that occurred in many women with this disease.

Leprosy, as seen in a ninety patient leprosarium, showed, in addition to the usual manifestations, a predilection for the scalp. A great loss of scalp hair thus occurred, except for a tuft along each temporal artery, thereby producing a configuration ont commonly seen in Caucasians with this disease.

* * *

In the seven hundred autopsies on Chinese refugees, not one instance of well developed *atherosclerosis* was noted. Likewise not one death due to coronary sclerosis with myocardial infarction was recorded. This low incidence of atherosclerosis in the middle and low class Chinese appeared to be in accord with the many reports ascribing this disease to a dietary basis. The cholesterol containing foods, chiefly animal fats, are eaten very little by these groups of Chinese people. However, the wealthier Chinese who can afford to eat these foods do develop atherosclerosis and coronary heart disease as shown by study of clinical material. Diabetes and diabetic gangrene was not seen in any of the material studied.

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* Read before the Section on Pathology and Bacteriology at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

There was a complete absence of *cholelithiasis* in the seven hundred autopsies. This observation was substantiated by the rarity with which gall bladders were seen in the surgical pathology material. Cholelithiasis did not appear to be a disease of the middle and low class Chinese. However, a further study showed that the few cases that were noted were among the wealthier Chinese, and again these were the ones whose diets simulated the foreign type with a greater amount of cholesterol containing foods than was eaten by the lower classes. In the seven hundred autopsies there were many instances of typhoid fever and in these gall bladder ulcerations were seen, three with perforation. Observation on the Chinese people seemed to show that infection of the gall bladder alone would not produce stones. It was impossible to tell whether the cases seen in the wealthier groups had had infection of the gall bladder. However, it appeared that probably a high cholesterol intake was the prominent factor in the development of cholelithiasis in these people.

Bright's Disease was not observed in the seven hundred autopsies. This finding was substantiated by the occurrence of only a few scarred kidneys, and they were shown to be due to pyelonephritis associated with tuberculous or other urinary tract infections. The absence of glomerular nephritis was probably associated with the rare occurrence of scarlet fever and similar acute diseases. The absence of nephrosclerosis was associated with the low incidence of hypertensive disease. In the same material there was not a typical hypertensive heart. A study of clinical material, in the same area, revealed the hypertensive disease was practically unknown in the middle and lower class Chinese. However, among Chinese bankers, lawyers, doctors, business men, and officials the disease did occur and its fatal complications were frequently seen. The relationship of the rice diet to hypertension is interesting. All classes of Chinese eat large amounts of rice, yet, there is the difference in frequency of hypertension among the classes of the population. Is there a particular virtue in the rice or is some other factor eliminated in certain rice diets? I was impressed with the latter view. Also, there are probable hereditary and neurogenic factors. In a Japanese concentration camp we observed a general lowering of blood pressure in the inmates. After a few months of diet consisting largely of rice, with general weight loss, most systolic pressures were below 120 mm. Hg. even though many said they had been running relatively high blood pressure for a long time. Lessened activity, definite routine, including specified hours of sleep, and more or less resignation to the inevitable, also seemed to be important factors in the general lowering of the blood pressure.

The various types of *vascular tumors* were frequently seen. Telangiectatic skin lesions were very common as were subcutaneous and deep cavernous hemantiomata. Cystic hygromas of the neck were seen and smaller lymphangiomata of the extremities and body were not uncommon. Many of these became infected through various needling practices and presented complicated inflammatory structures.

* * *

Sarcomas of all kinds and locations were common. Many instances of fibrosarcomas of the feet and legs come to mind. Massive myxosarcomas and chondromyxosarcomas were seen. Lymphosarcomas, especially reticulum cell in type, was especially common and occurred often in nasopharynx and neck. Clinically, the differential diagnosis was important because of the frequent occurrence of tuberculous adenitis. *Hodgkin's disease* was not seen in any of the material studied. Several *leucemias* were observed and the majority of these were of the acute type, but chronic myelogenous and chronic lymphatic types were seen.

Nevi are very common among the Chinese, many of them of the hairy type. However, in both the autopsy and surgical material, melanomas were not recorded except for two instances of choroid melanomas of the eye. One might surmise that in addition to being of brunette type, the relatively clear skins of the Chinese, the loose type of clothing, and the lessened demands for such practices as shaving may have some influence on the rare occurrence of these malignant tumors.

* * *

Carcinoma was varied in occurrence. Cancer of the lip was hardly seen. Probably the old custom of use of water-cooled pipes and pipes with very long stems may be a factor. Bronchogenic carcinoma was not seen in the seven hundred autopsies but a small number of cases were studied elsewhere. One was impressed with the low frequency as compared to this country.

Carcinomsa of the nasopharynx and the accessory sinuses were common adn may be related to the frequency of sinusitis and nasopharyngeal infections among the Chinese. The Chinese people, in the Shanghai area, rarely have artificial heating even in the coldest of winter weather.

Carcinoma of the esophagus was frequently seen and appeared to be associated with the custom of taking all food and drink as hot as could be tolerated.

Carcinomas of the stomach were seen in the older age group. Likewise papillomas and carcinomas of the large intestine were noted. In the seven hundred autopsies there was a fair series of schistosoma japanicum involvement of the large intestine, and in three of these, cancer of the colon had developed in hyperplastic papillomatous areas of the irritated mucosa.

Carcinoma of the penis was a common tumor. The high incidence of phimosis, with retained secretions and infections, appeared to be the important factor. Circumcision is not practiced among the Chinese.

In the postmortem material available on the middle and low class Chinese there was not a typical peptic ulcer of the stomach of duodenum. However, this disease was found in Chinese middle school and university students and in the business and professional classes, but altogether much less frequently than in this country.

In Chinese women carcinoma of the cervix is very common. Many more of them were in women under thirty years of age than is seen in this country. This might be associated with the relative early age of child bearing as compared with our population. Carcinoma of the breast was the next most common cancer in the Chinese women and seemed to occur in those who had borne children. The relationship to lactation was not determined.

Much interest has developed in the relative frequency of *carcinoma of the liver* in the Chinese. In the city of Shanghai many cases were observed and the frequency seemed to be as great as the reported incidence in other Chinese areas. The Shanghai Chinese do not have clonorchis sinensis infestation of the liver, yet cancer of the liver appeared to be as common among them as in the Canton Chinese, where the incidence of clonorchiasis reaches as much as seventy-five per cent of the population. The cases observed in the Shanghai Chinese did not have schistosoma infestation and the schistosoma patients did not happen to have cancer of the liver. In Shanghai we were of the opinion that parasitic infestations were probably not of importance in the etiology of primary carcinoma of the liver. Some of the hepatic cancers were associated with portal cirrhosis and some were not. Portal cirrhosis was fairly common and usually was not on an alcoholic basis. Fatty livers were seen in children and adults with severe bacillary dysentery and some other acute infections. Probably long standing dietary deficiency was also a factor. We were in the process of studying the relationship of this type of fatty liver to protal cirrhosis when the war interfered.

* * *

Observations concerning the occurrence of *benign hyperplasia of prostate* in Chinese men seems to be variable. Several urologists have stated that they have found this condition in Chinese in this country. In the seven hundred autopsies on Chinese refugees there was not one instance. In a special study of surgical material in several hospitals in Shanghai only three cases were found. There was no transurethral resection material, and several urologists in the city stated that they had not had enough cases to become familiar with the disease. No adequate reason for the apparent low occurrence of benign hyperplasia of the prostate in the typical Chinese population could be elicited.

Leiomyomas of the uterus occurred in all classes of the Chinese women but appeared to be much less common than in this country. In the seven hundred autopsies there were only four instances of very small tumors. In routine surgical pathology material a few fibroids were seen but not nearly as frequently as is seen in any pathological material here. Again no adequate reason for this low incidence could be found. In contrast was the very common occurrence of ovarian tumors, chiefly of the cystic types, some of which were of extreme size.

IN CONCLUSION

In conclusion, attention is again called to the contrast in frequency of occurrence of many pathological conditions between the Chinese in their natural environment and the Americans. Some of the factors responsible for the differences may be summarized as follows:

1. Differences in racial immunity as regards susceptibility and resistance to infection.
2. Difference in customs and habits of life.
3. Dietary differences.
4. Hereditary differences.

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CRUSHING INJURIES WITH RENAL FAILURE*

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The Crush Syndrome occurs following massively necrotizing injuries, usually to the extremities, with destruction of muscle and commonly results in the fatal suppression of renal function. It has been observed frequently following air raids, when individuals have been pinned beneath heavy debris. It has emerged from the war as a well recognized clinical entity. There is now a sizable literature in English pertaining to it. Although it had been described sporadically as a consequence of civilian injury in a few foreign papers, certainly it had been overlooked, or not reported, here or in Britain, until the devastating "Blitz" of large communities in England during 1940-41. It was then that the clinicians pointed the way to substantiative animal experimentation. Until then, and for reasons now evident, the experimentalists had not produced the condition in their extensive studies of the pathologic physiology of injury. The subject is still a timely one, inasmuch as air raids are continuing (with the enemy bearing the brunt of the attacks) to such an extent that more explosives may be delivered in a single raid than fell in the entire period of the "Blitz." Then, over 70 authentic cases of Crush Syndrome were reported and it is estimated that in a raid of a center of population, about 5 per cent of casualties may be of this type.

We must be alert to the possibility of the development of the syndrome in future civil practice in mining, traffic, industrial, mob stampede accidents, etc., for only in this way can it be averted. It is probable that many cases have been missed because exclusive attention was paid to the surgical aspects of the severe lesions.

The author has observed the condition in civilians in England and herewith reports two cases in United States Army personnel, having ethiologic mechanisms which vary from the usual mode of trauma.

RELATION TO SHOCK AND EXTRA-RENAL AZOTEMIA

The entire conception of "shock" from a practical, clinical viewpoint has undergone revision. It is now accepted that many types of trauma,—burns, lacerations, hemorrhage, infliction of pain, crushing, freezing, frightening, etc., all yield specific results, but that they all have in common certain clinical manifestations which are called "shock" (a word which should always be enclosed in quotation marks) and are characterized by pallor, sweating, etc. These manifestations are conspicuous and are common to them all, but they are only parts of diverse processes, activated by these different traumata. The conception of "shock" as an entity, with cause and mechanism, has done more harm than good. Each specific trauma has its specific response, although of course, two or more may co-exist.

Table 1.—*Factors in the Production of Clinical "Shock"*

(1) Fright (Emotional "shock")
(2) Post-Traumatic Hypertension
(3) Effects of tissue trauma
(4) Neurogenic "shock"
    (a) Vasovagal
    (b) Brain Injury
(5) Oligemic "shock"
    (a) Blood Loss
    (b) Plasma Loss
(6) *Crush Syndrome* (Renal failure)
(7) Blast Injuries
(8) Effects of Toxic Gases
(9) Effects of Anesthesia
(10) Circulatory Collapse—Mechanical Causes
    (a) Fat Embolism
    (b) Pulmonary Embolish
    (c) Coronary Thrombosis
(11) Toxemic "shock"
    Infection—Bacterial toxins
(12) Dehydration Collapse (may play a part in war injuries) diarrhea, vomiting, etc.

Then too, renal function may be impaired as a result of a disturbed normal physiologic balance in surgical situations where the element of trauma does not play a primary part. When this factor becomes involved in cases of severe injury, the situation is further complicated. Extra-renal azotemia (the elevation of the non-protein nitrogenous blood elements without primary kidney damage) may occur as a result of one of the following:

1. A drop in blood pressure which affects the hydrostatic pressure in the glomerulus and consequently lowers the potential for glomerular filtration. Under spinal anesthesia, for instance, the volume of urine diminishes directly with the fall in blood pressure and ceases altogether with systolic pressure has reached 70 mns. of mercury.

2. Hypochloremia and hyponatremia may occur with persistent vomiting, gastrointestinal fistulae, diarrhea, rhinorrhea, excess sweating, evaporation from denuded epithelium, and polyuria. These result in the loss of both sodium and chloride and it is probable that urea is retained to maintain osmotic pressure. With sodium loss, regardless of fluid intake, there is a diminution in blood plasma. With chloride loss, there is a concomitant loss of fluids. The loss of either also upsets the acid base balance. Kidney function is diminished.

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3. Dehydration. With a specific gravity of 1.032, there must be at least 500 to 600 ccs of urine a day to excrete the 35-40 grams of catabolic solids produced in this length of time. With decrease of blood flow through the kidneys, there is a diminution of glomerular filtrate.

4. In the hepatorenal syndrome, the interrelation between liver and kidney dysfunction is demonstrated.

5. Many abnormalities of protein catabolism, such as are found in local infections, peritonitis, pneumonia, septicemia, and severe surgical trauma occur. With proper renal function and available fluids, the increased rate of protein catabolism can be taken care of by the kidneys, but the changes may be too rapid for the kidneys to adjust themselves.

In all of these instances of prerenal azotemia, the damage to the kidneys may be merely functional and reversible, but actual morphologic changes may occur. They are therefore to be considered in their relation to the pathology found in the Crush Syndrome.

CLINICAL MANIFESTATIONS OF THE SYNDROME

The clinical appearance of fatal renal failure following a crushing injury can best be described by citing a typical case. The patient is brought to the hospital after having had pressure applied to his limb or limbs for a period of from one to several hours. If there have been many casualties involved in a catastrophe, he will be one of the later arrivals. When first seen, on admission, his general condition may be good, provided he has sustained no other serious injuries. The pulse and blood pressure may be normal. There is some swelling of the limb and there may be some local anesthesia. Shortly wheals may appear at the site of crushing. Local edema slowly makes its appearance and spreads along the extremity. Movements of the affected part become limited or absent altogether. Various sensory disturbances, such as anesthesia, hyperesthesia, or paresthesia, may or may not occur. There may be intense arterial spasm, although the peripheral arterial pulse is not invariably absent when the patient is first seen. In a few hours the hemoglobin becomes raised, the blood pressure decreases and the picture of "shock" may ensue. This may be combated successfully by transfusions of serum, plasma and blood. The urine is diminished in quantity, contains albumen and many dark brown and black granular casts. The patient is alternately drowsy and anxious. Thirst and excess vomiting are common. The blood urea and potassium gradually rise while the chlorides and CO_2 combining power fall. There is progressive accentuation of all these abnormalities until death ensues in about one week.

Table 3.—*Biochemistry of Normal Muscle*

Cell $\longrightarrow$ K^+ $PO_4^{=}$ Myohgb.

Serum $\longrightarrow$ Na^+ Cl^-

Table 4.—*Blood in Crush Syndrome*

	Normal	Crush
K^+	18 mgm. %	30 + mgm. %
$PO_4^{=}$	3 mgm. %	7-9 mgm. %
CO^2 c.p.	50 vol. %	28-32 vol. %

Autopsy reveals necrosis of the muscle. There are degenerative changes in the renal collecting tubules. They contain casts in which is brown pigment. These casts, microscopically, are not composed of red blood cells, but rather of desquamated epithelial cells and a pigment which has been shown to be myohemoglobin. Grossly and microscopically, the kidney has an appearance similar to that found in mismatched transfusion. However, there has been no evidence of such a mismatched transfusion,

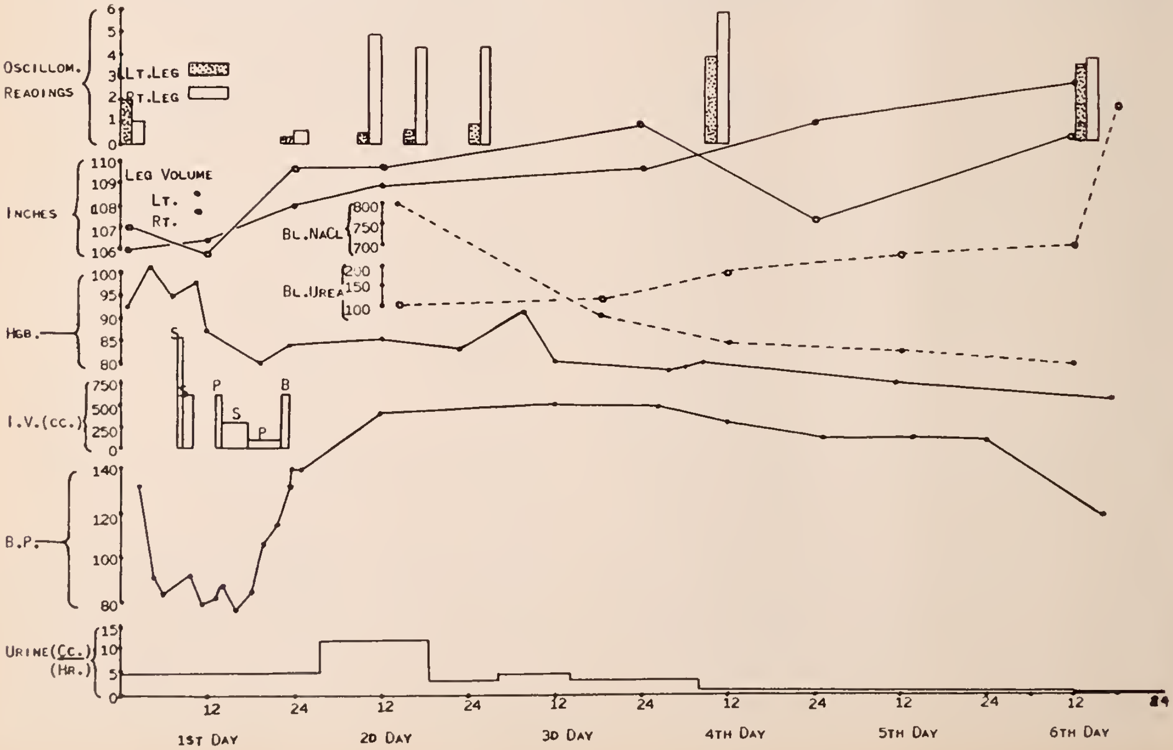

Chart 1.—Clinical course of a crushing injury case.

or possibly of any transfusion at all and the pigment can be shown chemically and spectroscopically, not to be hemoglobin.

PATHOGENESIS

Although there is some controversy concerning the cause of renal failure, the weight of evidence seems to be that it occurs as a result of mechanical plugging of the tubules by precipitation of myohemoglobin from the injured muscle in an acid urine. In the normal muscle cell are the potassium ion, phosphate ion and myohemoglobin while in the surrounding serum are the sodium ion and chloride ion. (See Chart 3.) The coloring of the muscle in man is myohemoglobin. Normally, there is no interchange through the cell membrane. A heavy object then cuts off the blood supply for a time sufficient to destroy the normal physiologic balance between cell and serum. The object is removed and eventually blood supply is brought to and through the dead muscle. The selective permeability of the membrane is lost and potassium, phosphate and myohemoglobin circulate in the blood stream. Table 4 illustrates the manner in which the blood levels of the first two elements are increased. The myohemoglobin blood level is not elevated because it has a low renal threshold. The size and shape of its molecule are such as to permit its removal from the blood stream. In the kidney tubules, because of the acid reaction and other factors, it is percipitated and renal failure ensues. The most important criticism of the blockage theory is that if tubular obstruction alone were concerned, such urine as was secreted should theoretically be of normal composition, coming from unobstructed tubules. The urine in these cases, however, is little more than a glomerular filtrate with a urea concentration factor of from 1.6 to 2.8. Among acute renal conditions the greatest reduction in the cencentrating power is where there is severe damage of tubular epithelium.

Of interest is the similarity of the paralytic myohemoglobinemia found in horses. After periods of rest and rich feeding when horses are suddenly and strenuously exercised there may result acute stiffness, swelling, paralysis of the muscles, hemo-concentration, thready pulse, acidosis, and the appearance of muscle pigment in the urine. If the animal dies, some muscles are found to be pale and necrotic, looking like the pale flesh of fish. Seven such cases in man have been reported. Pathologically, the kidneys have an appearance similar to that found in the Crush Syndrome.

In some of the few cases of Crush Syndrome which have gone on to recovery, ischemic paralysis has occurred. One occasionally sees such instances of foot drop following severe injury where a record of study of the individual's physiologic and biochemic response at the time of injury are not available. At this meeting, two years ago, several cases of arterial spasm and subfascial tension of muscle in soldiers resulting in ischemia, necrosis, and Volkman's syndrome were reported. Data concerning renal function of these individuals was not included.

TREATMENT

The treatment of the Crush Syndrome is aimed at alkaline diuresis. The natural tendency under emergency conditions is to treat shock first, the injured extremity next, and then on the third or fourth day, to attend to the renal failure which is then making its appearance. However, here treatment should be just the reverse, since renal damage occurs only after there is an adequate blood supply to the limb. Ideally, the individual should have liberal fluids, such as coffee, tea, and water with sodium bicarbonate before he is released from the weight which imprisons him. Tourniquet may be applied at or proximal to the injured site until admission to the hospital. There sodium bicarbonate, 4 grams hourly, until the urine is alkaline and 30 grams a day for two days may be administered. Isotonic sodium lactate, 3-4 per cent sodium citrate, or 1.4 per cent sodium bicarbonate, in that order of preference, may be given intravenously.

After the urine has been alkalinized, one should then attempt to improve the circulation to the injured part. The limb should be kept cool to decrease autolysis and lower the margin of blood supply. It should be immobilized to reduce absorption and "shock." Splitting of tense fascial spaces, pressure dressings or casts, the treatment of vasospasm, amputation, etc., have their indications.

The treatment of the "shock" should follow or be concurrent with alkalinization. There may be leakage of plasma with no external manifestation and oligemic "shock" may ensue, although the blood pressure may remain normal as a result of compensatory vasoconstriction. Since renal function may be further impaired, one must recognize the "preshock" stage. Serum blood plasma must be given *before* there is a fall in blood pressure. Opiates are given for pain. The patient is *not* heated unless he complains of real coldness and then blankets may be used.

The value of mercurial diuretics, decapsulation of the kidney, administration of insulin and dextrose to mobilize the excess potassium, passive vascular exercise, etc., have been employed but are of questionable value.

REPORT OF CASES

The following cases exhibit the renal pathology in question. Neither, however, had a crushing injury such as described above, although both had extensive muscle damage. The first case was seen in the 30th General Hospital overseas and the clinical record is not available. The history is recited from brief personal notes made by the author and hence is very sketchy. The second occurred in this country. Major Frank Shea, M.C., Army Air Forces, Chief of Surgical Service at March Field, California, has been kind enough to allow me to refer to it. It is to be reported in further detail at a later date.

Case 1.—(30th General Hospital, European Theatre of Operations.) Six hours before entry, the patient had been in an air raid over Europe in a B-17 bomber. He had been struck in the right lumbar region and left thigh by flak. He had been in moderate shock at this station upon return and had been given 500 cc. plasma and morphine there. The leg was fixed in Thomas traction. He was then driven to the 30th General Hospital by ambulance. Upon entry, he was conscious and pale, pulse 120, blood pressure 90/50. Chest normal. Abdomen showed slight tenderness throughout and was markedly guarded. There was some shifting dullness in the flanks. Peristalsis was absent. There was a compound fracture of the femur with the proximal fragment driven anteriorly and imprisoned in a buttonhole in the anterior fascia. There was a jagged wound of the right lumbar region. X-rays showed the fragment to be in the upper abdomen on the right. R.B.C.—3.6 million. Hgb.—100 per cent. Patient was treated for shock and then operated upon under inhalation anesthesia. The abdomen was entered anteriorly. There was 250 cc. clotted blood intraperitoneally. The right kidney, especially in its upper half, was shattered. There was a stellate laceration of the inferior surface of the right lobe of the liver. Right nephrectomy was performed. A fascial incision was made over the proximal femoral fragment to release it. Skeletal traction was applied. Postoperatively, the patient recovered consciousness, but was never fully oriented and soon lapsed into coma. There was facial twitching. The blood pressure was, at times, 170/0 with Traube's pistol shot sign and Corrigan pulse. Pulmonary edema developed. There was anuria for the first 36 hours and then incontinence of a few cc's. of brownish urine containing dark, granular pigment. The blood urea rose steadily. Death occurred on the fifth day. Autopsy showed considerable damage to the lumbar and thigh muscles. There was pulmonary edema. The spleen was enlarged and congested. The operative site disclosed on abnormality. The abdomen was otherwise normal. The remaining kidney was large and swollen. Microscopically it showed changed characteristic of the Crush Syndrome.

Case 2.—Lt. R. D. Crash landing.—Patient pinned underneath wreckage. Minor fractures several transverse processes and 12th rib. Left thigh, minor contusion at junction mid-and-upper thirds. Flying suit and clothes drawn tightly around thigh as tourniquet for 4½ hours. While entrapped, morphine and plasma given and patient conscious and in good spirits. Immediately after removal, passed into deep shock. Accident at 2218 hours; admitted to hospital at 0330 hours. Examination disclosed reddish discoloration of thigh. Dorsalis pedis palpable. At 0800 huors examination showed board-like calf, painful, reddish-blue mottling of skin. Foot-drop but able to raise toes. Peculiar sensory changes. First voided at 1100 hours, 600 cc., brownish-black. That evening at 1800 hours into shock. RBC: 7.4 M. Hematocrit: 65. Plasma and saline. Responded well. Blood pressure always high—first day 150/100 to 240/112 on day of death. Pulse 80-90 throughout. Urinary output always small: 105 cc. to 21 cc. on last day. NPN: 114 to 235. Urea nitrogen: 46-140. Creatinine: 3.5 to 14.2. CO_2 combining power never below 40 volumes per cent. Blood chlorides ranged from 530 to 580. No whole blood given. Generalized, progressive edema. X-ray, November 23, 1944, patchy areas lower portions both lungs. Possible early pulmonary edema. I. V. Pyelogram day of entry showed both kidneys of normal size, outline and position. Superior and inferior calices on left faintly outlined with dye, but only superior calices on the right visualized.

Autopsy:

Generalized pitting edema; both legs swollen and edematous. 500 cc. sero-sanguinous fluid in right pleural cavity and 800 cc. in left pleural cavity. Dark, reddish-purple areas, firm, posterior surface both lungs. Heart: 410 gms. Somewhat larger than normal, due to dilated right ventricle and auricle. Spleen: 210 grams, larger than normal. Chronic passive congestion. Right kidney: 225 grams. Left kidney: 210 grams. Small hemorrhage in capsule upper pole right kidney with superficial laceration 2 x 1 cm. beneath it. Kidneys pale, normal cortical markings obscured. Right cortex: 10 mm., left—7 mm. Bladder collapsed, 1-2 cc. cloudy, smoky urine. In the vastus intermedius were bundles of muscle fibers, grayish yellow, standing out sharply in contrast to surrounding edematous, purplish-brown normal muscle. Similar necrotic muscle in the calf of the right leg. Femoral artery and vein contain no thrombi. Microscopic: Right kidney: glomeruli appear avascular due to collapsed capsule. Cells around opening in uriniferous tubules markedly swollen. Cells of convoluted tubules so swollen that lumen is occluded at many points. In medullary portoin, collecting tubules have dilated lumina which are plugged with (1) red blood cells, (2) hemoglobin or acid hematin stained cells, (3) cellular debris. Latter consists of small cuboidal tubular cells or large cuboidal cells showing degeneration or mixture of polymorphonuclears, plasma cells and small cuboidal cells. Left: shows similar changes. Muscle: All stages of degeneration and necrosis. Cross striations are lost. Proliferation of nuclei at periphery and hemorrhage in connective tissue. Some fibers completely missing. Some show fragmentation and loss of nuclei. Spectographic analysis of urine reveals majority of pigment to be myohemoglobin. Smaller amount of methemoglobin was present.

DISCUSSION

Neither case was incurred in the manner commonly described, namely by being pinned beneath heavy fallen buildings, etc. The second had the effect of tourniquet action by his clothing. It has been hypothesized that this could occur in instances where tourniquets were inadvertently allowed to remain in place for too long periods but no cases are recorded. Both had actual trauma to a kidney as well as destructive injuries of the skeletal musculature. The element of a '"reflex anuria" may well have been superimposed to abet the process of pigment deposition in the renal tubules, as well as to disturb the ether physiologic processes previously described. In the first case, liver damage was also present. Both, of course, suffered from oligemic "shock" as well.

SUMMARY AND CONCLUSIONS

1. The Crush Syndrome occurs following necrotizing injuries to muscles through which blood is circulating, resulting in the absorption of substances abnormal to the blood and their excretion into the kidney. Renal failure then occurs, probably as a result of mechanical blockage although other factors may play a part.

2. The condition may occur in civil life and be overlooked.

3. The mechanism of injury is usually a long period of crushing by a heavy object but may occur by other means.

4. Other physiologic factors seen in a variety of surgical conditions may reflect upon kidney function and enter the picture of Crush Syndrome as complicating elements. "Reflex anuria," due to trauma to a kidney itself may be responsible for acceleration of the chain of events.

5. Prompt and early recognition of the possibility of renal damage in severe injuries must be made if therapy is to be of value. Treatment is aimed at alkaline diuresis before the blood supply to the extremity is revived, treatment of "shock" and restoration of the injured region.

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PHLEBOTHROMBOSIS, THROMBOPHLEBITIS AND PULMONARY EMBOLISM —PRESENT CONCEPTS*

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Thromboembolism

INTRAVENOUS thrombosis is of major importance because of its complications and sequelae. There are two principal types of intravenous clotting—those with a manifest inflammatory reaction and those without. The last group is the most dangerous because of the difficulty of early detection. Frequently the first evidence of its existence is a pulmonary embolus. The only group that requires special emphasis is the quiet deep venous thrombosis, phlebothrombosis. It has been repeatedly emphasized by Ochsner and DeBakey[69,71,72,73] that phlebothrombosis must be distinguished from thrombophlebitis because of etiologic, clinical, prognostic, and therapeutic differences. The dread complication of pulmonary embolism is real, as is indicated by reported statistics as to its incidence and the number of fatal cases that occur. Reports from various sources show an incidence of from less than 1 per cent to almost 12 per cent of routine autopsies. Domrich[27] in a review of 26,439 necropsies, noted pulmonary embolism in 0.5 per cent, and in another series of 2,500 examinations, an incidence of 2.4 per cent. Belt[23] recorded an incidence of 9.8 per cent of 567 examinations, and Breslic[88] found 11.8 per cent in 457 necropsies. Hunter et al[47] in a review of 351 autopsies reported that fatal pulmonary embolism was responsible for 3.13 per cent of all deaths. In a subsequent review of 200 autopsies they[46] observed 11 deaths and 28 instances of non-fatal embolism. McCartney,[61] in a review of 25,771 necropsies from the University of Minnesota, from 1919 to 1938, noted 689 instances (2.67 per cent) of death attributed to pulmonary embolism. This is most certainly not only a surgical problem but the concern of every doctor. Hunter and his collaborators[46] in a study of 200 autopsies found 11 deaths from pulmonary embolism. Of these deaths, six were surgical cases and five medical.

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Reports on the incidence of thrombosis and embolism following surgical procedures vary from 0.02 to almost 1 per cent. In 1912, Wilson[98] reported on 63,753 operations done at the Mayo Clinic and an incidence of embolism of 0.07 per cent whereas Heard[39] in 1923, at the Mayo Clinic, found an incidence of embolism of 0.12 per cent in 60,727 operations on men, and of 0.07 per cent in 43,605 operations on women. In 1940 Barker and his associates,[5] also reporting from the Mayo Clinic, showed an incidence of thrombosis and embolism of 0.96 per cent in 172,888 operations, of pulmonary embolism of 0.52 per cent and of fatal embolism of 0.20 per cent. They found that the incidence of fatal pulmonary embolism varied from 0 to 0.77 per cent. It is stated that there is a seasonal incidence of pulmonary embolism, but this is subject to some disagreement. De Takats and his co-workers[24] in a study of 100 cases of pulmonary embolism notes that the greatest incidence was during the spring and fall of the year with the greatest fluctuations of barometric pressure and temperature. Martland[60] found that in 86 massive embolisms in 10,797 necropsies from his medical examiners service, that March, April, September and December were the months with the greatest incidence of pulmonary embolism. McCartney,[61] on the other hand failed to show much difference. He also notes that thrombosis of the deep veins of the leg is appallingly frequent among middle-aged and old persons forced to bed for varying periods of time, the incidence of thrombosis being 52.7 per cent, with bilateral involvement 110 times, and unilateral involvement 75 times. In a survey of 4,070 postoperative deaths, Culp[14] in a study of 88 embolisms found that 62.5 per cent were present in persons over 60 years of age whereas only 41.2 per cent of all patients were over 60 years of age. McCartney[61] found venous thrombosis of pulmonary embolism in 471 instances or in 11.5 per cent. He considered that in 216 instances the pulmonary embolism could be called fatal (5.3 per cent). There were 1,506 women with 182 thromboses and embolism (12 per cent), and 2,564 men with 281 instances of thromboembolism (10.9 per cent). In the 1,505 women there were 90 fatal embolisms (5.9 per cent) and in the 2,564 men 126 fatal embolisms (4.9 per cent). There appears to be little difference in the sex distribution. McCartney,[61] in his study of 25,771 autopsies, found thromboembolism occurring in 9.1 per cent of men and 11.2 per cent of women, and fatal embolism in 2.2 per cent of men and 3.3 per cent of women. Veal and Hussey,[93] in a review of 84 cases of deep venous thrombosis of the lower extremity, reports that 55 of the patients were men and 29 women. Hunter, et al,[47] on the basis of findings in 351 cases of deep venous thrombosis, observe that 52.2 per cent were men and 53.5 per cent were women. The incidence of thromboembolism occurred in the following order postoperatively: uterus, hernia, extremity, bladder, perineum, head, kidney, large intestine, appendix, miscellaneous, thorax, gall-bladder, adnexa, small intestine neck, exploratory laporatomy, stomach, spine; and fatal embolism in the following order postoperatively; hernie, uterus, bladder, gall-bladder, perineum, adnexa, kidney, appendix, extremity, large intestine, small intestine, thorax, exploratory laporatomy, stomach, miscellaneous, head, neck. This demonstrates that thromboembolism can occur as a consequence to operation in any part of the body. Culp[14] noted that there were 88 pulmonary embolisms of which 32 were fatal in a survey of 8,163 urologic operations. Embolism was responsible for 6.62 per cent of the postoperative deaths. The incidence of fatal embolism after suprapubic operations was 0.67 per cent, after perineal 0.57 per cent, and after transurethral 0.25 per cent.

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Aschoff's[2] theory of thrombosis, the one most generally accepted, states that most of the fatal emboli come from thromboses of iliac and femoral veins. The thrombus usually begins near a valve as a platelet or agglutination thrombus, and this forms the head. When this platelet thrombus has become large enough to occlude the vein, a coagulation thrombus made up of fibrin, red blood cells, and leucocytes forms in the obstructed vein where the blood is at a standstill. There is some dispute of this in recent years with the findings of Olow,[76] Denecke,[17] Roessle,[85] Neumann,[66] Frykholm,[35] and others, that many of the thromboses may have started in the veins of the feet and legs. The source of a pulmonary embolus is frequently difficult to determine. Anatomically, when the lower extremity is the source, the tributaries of the inferior vena cava are implicated. Anatomical dissections and clinical investigation in a large series of cases[5, 35, 46, 47, 61, 66, 83, 85] demonstrate that the veins of the lower extremity are most frequently involved, particularly in the leg or below, and are the most frequent source of pulmonary emboli. Frykholm,[35] in 133 cases of venous thrombosis discovered by anatomic dissection, observed that in 85 per cent the process was distal to the entrance of the profunda and most of these were below the knee. Neumann[66] observed that of 165 unselected cases, studed in a like manner, 100 had venous thrombosis. Thrombosis in the veins of the thigh were present in 45 per cent, but in each instance as a continuation of thrombosis, with intervals of freedom at those points in the lower extremity where compression is likely by extravenous structures. The foot veins were involved in 71 per cent, the leg veins in 87 per cent, and the thigh veins in 22 per cent. The calf veins were more often affected alone (29 per cent) than were the plantar veins alone (12 per cent). Of his 100 subjects with thrombosis of the lower extremities, 11.8 per cent had fulminating fatal pulmonary embolism, and of these, more than 80 per cent had clots in the veins of the feet and calves. If one includes the cases of non-fatal multiple emboli, the lower extremities account for 52.8 per cent of the clots lodging in the lungs.

Neumann[66] postulated two clinical types of thrombosis, based on the site of origin; (1) a benign variety, starting in the veins of the legs and characterized by slow progression of the clots, increasing in frequency with age and having a tendency toward multiple but non-fatal emboli; and (2) a malignant form, centered in the plantar veins and typified by rapidly progressive thrombosis, occurring in younger people, not rising in frequency with age, and tending toward fulminating, fatal embolism of the lungs. Virchow,[95] in 1846 published the first correctly interpreted examples of clot embolism and felt that the clot obstructing the pulmonary artery came from the veins of the pelvis or lower extremities. This concept has been maintained to the present time. Frequently the first sign of such an embolism will be the occurrence of a infarct in the lung.

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The diagnosis of phlebothrombosis is thus extremely important and must begin with a suspicion. Detection is only on the basis of repeated examination of the extremities, by measurement of the extremities, palpation, careful observation of the pulse rate and temperature,[58, 70] and blood sedimentation rate.

Phlebography has been given extensive trial as a diagnostic adjunct in the detection of phlebothrombosis but is subject to the criticism of inconstant visualization of various veins, failure of visualization of plantar veins, and lack of venous patterns that can be labeled as diagnostic. In 1931, Sgalitzer and Kollert[86] devised a technique for roentgen visualization of varicosities by direct injection of radio-opaque substances into the vein. They used 40 per cent uroselection or 20 per cent abrodil and they reported one case of hemangioma with excellent delineation of the venous tumor. Lesser and Danelius[55] credit Dr. Barney Brooks as originally employing the intraarterial injection of sodium iodide for radiographic visualization of the main and collateral vessels in 1924. Bauer,[6] Doughterty and Homans,[31] Fine, Frank, and Starr,[34] Allen, Linton, and Donaldson,[1] Ochsner, DeBakey and Schroeder[75] and others[28, 29, 30, 33, 55, 59] have written much about their experiences with this method. Fine and Sears[33] in 1941 stated that "preoperative venography by the technique of Bauer promises to render other methods obsolete." More recently the senior author[34] dismisses phlebography with the statement that "we have, with increasing experience, come to find the value of venography much more limited than we had believed," because the disease may be present without phlebographic evidence, spasm may confuse the interpretation, and when one side has been ligated very often there will be no phlebographic evidence of thrombosis on the other side, and in the meantime the individual may develop another embolus. Allen, Linton and Donaldson[1] are less inclined to rely on this procedure. They found positive clinical evidence of thrombi with negative phlebograms in one-third of the cases and are coming to depend on clinical evidence. This conforms to what can be expected on the basis of pathology of thrombosis in the veins of the legs and feet as has been discussed above. We have employed phlebography routinely on all cases of suspected venous pathology and obstruction at the Vascular Center at DeWitt General Hospital, except in cases of active superficial phlebitis. This is a definite and absolute contraindication to phlebography because of repeated experiences of reactivation of a supposedly inactive superficial infection.

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A review of 136 phlebograms done on 110 cases shows the following distribution:

	Right	Left	Total
Upper extremities	8	7	15
Lower extremities	49	72	121

The distribution of 492 veins visualized in 136 phlebograms of the lower extremities were as follows:

	No.	% Visualized
Iliac	68	13.8
Pudendal or epigastric	9	1.8
Superficial femoral	75	15.2
Gluteal	3	0.6
Deep femoral	65	13.2
Femoral collateral	35	7.1
Internal saphenous	75	15.2
Popliteal	72	14.6
External saphenous	15	3.0
Deep veins of the leg	75	15.2

Of these there were 42 cases of intravenous clotting reviewed as follows:

	Right	Left	Total
Upper extremities	2	1	3
Lower extremities	12	30	42

The types of cases were:

Chronic deep thrombophlebitis	35
Phlebothrombosis	3
Axillary Thrombosis	2
Migratory phlebitis	1
Superficial phlebitis	1
	42

In the 38 cases of deep venous clotting of the lower extremities 131 veins were visualized as follows:

Iliac	22	16.8%
Pudendal or epigastric	7	5.3
Gluteal	1	0.8
Superficial femoral	8	6.1
Femoral collateral	25	19.0
Internal saphenous	33	25.2
Popliteal	19	14.5
Deep veins of the leg	16	12.2

* * *

These figures indicate that the most common collaterals in the thigh are those along the femoral vein and the internal saphenous vein. A review of the phlebograms in the lower extremity reveal agreement with the clinical findings in the advanced cases of thrombosis or obstruction. Phlebography has been an aid in evaluating the cases of chronic deep thrombosis as to the degree and extent of obstruction and the amount of canalization. Canalization was demonstrated in 5 phlebograms, and, contrary to anticipation, these were the milder types of cases. In some cases phlebography accurately demonstrated the underlying pathology when a confusing history and clinical pattern presented itself. It is of definite help in evaluating the more severe types of varicose veins with multiple perforators which do not respond well to even multiple tourniquet tests. It is agreed that phlebography is of no value in the early detection of phlebothrombosis or even in its location when the condition has demonstrated itself by means of a pulmonary embolism. It is well to mention a word of warning that the procedure is not innocuous, as 26 deaths have been collected by Pendergrass, Chamberlain, Godfrey, and Burdick[79] from the use of diadrast for this purpose. We are able routinely to visualize the iliac vein sometimes to its entrance into the inferior vena cava. A conjunctival test for sensitivity to diodrast is done, the individual is questioned as to a history of hay fever and asthma, and a check made on the specific gravity of urine. If these findings are negative phlebography is done carefully, 1 cc. of diodrast being injected intravenously and waiting 2 minutes for any effect before continuing the injection. The individual is placed on an ordinary x-ray table with the x-ray tube 42 inches above the table. A 14 x 17 film is placed in a Bucky carrier so as to visualize the thigh, and a 14 x 17 film is then placed in an ordinary cardboard film holder from which the lead backing has been removed and a par speed screen has been substituted. The cardboard holder is placed beneath an ordinary portable field grid. Soft tissue x-ray technique is used for the exposure. For an average thickness thigh an average of 59-62 K.V. at 100 M.A. for an exposure time of one second is used with the tube centered over the patella. A vein is then selected on the dorsum of the foot, preferably on the lateral aspect, and novocain is injected into the skin as this is a very sensitive area. A No. 20 gauge intravenous needle on a 30 cc. syringe is then inserted into the vein and 30 cc. of diodrast injected in 45 seconds. An x-ray exposure is then taken. At the end of the exposure, the tourniquet, which has been loosely placed around the upper thigh so as to obstruct the internal saphenous vein, is made tight by the doctor twisting it. This compresses the entire venous system and the dye is retained in the extremity. The cardboard holder and cassette are removed and another cassette placed in the Bucky carrier. The Bucky carrier is then moved upward so that the next exposure will visualize the proximal portion of the femoral vein as well as the iliac vein and the x-ray technique changed accordingly. The x-ray change consists of a step up of 20 K.V. above the technique used for the thigh and leg and the time and M.A. are not changed. When all is in readiness the tourniquet is quickly removed and another exposure immediately made. This method has been satisfactory and obviates attempts to visualize varying thickness of tissues at one time and avoids surgical exposure of the veins at the ankle.

Allen, Linton and Donaldson[1] prefer determinations of the pulse, temperature and respiration every four hours postoperatively and, if there is any persistent or undue elevation of any one of these, feel that repeated examination for any clinical signs of phlebothrombosis should be made. It is felt that even small fragments of a propagating thrombi may effect the pulse rate, respiration, or temperature. DeTakats[21] feels that a slight rise of temperature and a persistently elevated pulse rate without apparent cause, after the fourth or fifth postoperative day, should make one seek signs of a latent thrombosis. He feels that skin temperatures of the foot are of value as well as soreness of the sole of the foot to touch. Allen and his co-workers[1] mention in the order of their frequency a number of positive findings. In their series, some degree of swelling was found in 67 per cent of the 237 cases examined, tenderness was found in 61 per cent of 231 cases, and in 139 cases, Homan's dorsiflexion sign was found. In 41 per cent of their series, pulmonary embolism, however, was the first evidence of deep venous thrombosis. Electrocardiographic changes in the early recognition of pulmonary embolism as a consequence of strain on the right ventricle have been stressed.[43, 62, 64]

Veal and Hussey[93] point out that of 84 cases of deep venous thrombosis of the lower extremity, in 16, pulmonary embolism was the initial symptom that directed attention to the venous thrombosis, and in 23 additional cases pulmonary embolism preceded surgical ligation of the vein.

* * *

The treatment of thromboembolism includes not only therapeutic implications but also prophylaxis. This has been emphasized by Ochsner and DeBakey.[70] In the production of intravascular thrombosis, there are predisposing factors and precipitating factors. Principally there is a combination of trauma, increased coagulability of the blood, and slowing of the circulation. Predisposing factors are cardiovascular disease,[9, 77, 82] seasonal variation,[71] foci of infection, varicosities, constitutional diathesis, degenerative vascular changes, age,[1, 90] smoking,[70] overweight,[40, 89] debility, decreased cardiac tone, anemia, polycythemia, malignant disease.[89] Injury to tissue as result of an operation, accidental trauma, delivery, or invasion by infection or malignant disease, results in increased coagulability of blood because of the absorption into the blood stream of noxious substances derived from traumatized cells. The increased blood coagulability is the result of changes in the plasma and the formed elements of the blood. The changes in the plasma consist of increased viscosity, hypoproteinemia, hyperglobulinemia, increased fibrinogen content, increased antitryptic power, increased peptidase, increased calcium content, decreased carbon dioxide combining power, and increased sedimentation rate. Thrombocytes and leucocytes become increased, and erythrocytes become decreased. Increased agglutinability of the thrombocytes occurs. It is therefore essential to prepare the individual for operation by improving his cardiac status, removing foci of infection, treating varicosities or having the individual wear compression bandages as advocated by Ochsner and DeBakey,[70] having the individual stop smoking immediately preoperatively and postoperatively, reduce weight, proper hydration, and correction of anemia. Operatively it is essential to employ atraumatic surgery with a minimal of tissue handling, sharp dissection, and absolute hemostasis with fine non-absorbable suture,[63] prevention of circulatory collapse and the avoidance of chilling. It is to be emphasized that merely putting an individual to bed predisposes to the formation of venous thrombosis. Hunter, Sneeden, Robertson and Synder[47] noted thrombi of various age to be present in 52.7 per cent of the 351 autopsies of unselected middle aged and elderly patients who had been forced to bed for varying periods before their death. They studied microscopically 209 pairs of soleus and gastrocnemii muscles. They observed that the thrombosis tends to be bilateral and will be found in and along the soleus muscle much more frequently than the gastrocnemius. Hunter, Krygier, Kennedy, and Sneeden,[46] in a comparative series of 200 autopsies done on individuals who had been in bed before death without exercise, and 200 autopsies done on individuals who exercised or were ambulatory to within 48 hours of death report that there was a reduction of leg vein thrombosis from 59 to 44 per cent (15 per cent). In the first group 59.7 per cent of the medical patients had phlebothrombosis of the calf, while in the second study it was 37.7 per cent, a drop of 20 per cent and they felt this was as a response to a planned increase in exercise of these individuals. They feel that the efficient return of the blood to the heart from the deep veins of the extremities depends on the circulation time, compressive action of muscles, mechanical obstruction, negative pressure in the abdomen and thorax, and gravity. Smith and Allen[88] in a study of 66 persons found that the most important influence on the time of the circulation of blood was the temperature of the skin of the extremities. The speed of flow was decreased when the skin was cool, and accentuated when it was warm, irrespective of how the vasodilatation was produced. Exercise and elevation had the same effect. Potts and Smith[81] following a study of 500 patients given exercises postoperatively (among whom there was no instance of venous thrombosis or pulmonary embolism) concluded that simultaneous deep breaths and active leg exercises at regular intervals would vary the blood flow, not only in the legs, but in the pelvic veins as well, and thus prevent stasis and venous thrombosis. Experimentally they demonstrated that elevation of the lower extremities in animals (dogs) or muscular contraction increased the blood flow markedly as measured by the venturimeter. To test the observation of Luckhardt, Alpert, and Smith[57] that the reflext inhibition of respiration will temporarily obstruct the return flow of blood to the heart, Potts and Smith[81] simulated this condition by over-inflating the dog's lungs. This stopped blood flow from the vena cava (inferior) almost completely and release of pulmonary obstruction showed a prompt return. Hunter, et al[46] stress that the common denominator of all phlebothrombosis and pulmonary embolism is confinement to bed. Dock[26] has recently emphasized not only the frequency of pulmonary embolism originating from the leg and pelvic veins of bedridden persons, but also other serious effects of confinement as well. Simpson[87] noted the striking increase in the number of deaths from pulmonary embolism among elderly people who entered shelters and would sit, night after night, with the pressure of the crossbars on the back of their thighs and on the popliteal vessels, with the legs dependent. It was noted that 24 persons had died from pulmonary embolism in 1940, in contrast to 4 in 1939. The condition causing this became known as shelter leg. Posture in bed ideally is flexion of the thigh on the trunk but no flexion of the leg as is used in Fowler's position. Friedlander[41] has shown that whereas flexion of the thigh on the trunk theoretically produces compression of the femoroiliac veins beneath the inguinal ligament such a position actually favors the return flow of blood. From the entire foregoing discussion it is obvious that deep breathing exercises should be done regularly by the individual with constant movement of his muscles and finally elevation of the extremities. Early ambulation is another important factor postoperatively in preventing retardation of blood flow and the prevention of thromboembolism. This has many advocates.[13, 99]

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Barker, et al have approached the problem of prevention by the use of anticoagulants. In a report[4] of observations on 1,000 surgical patients who were given dicumarol in their immediate postoperative period for the purpose of preventing venous thrombosis and pulmonary embolism they were able to prevent fatal pulmonary embolism even after the diagnosis of thrombosis had been made. A thrombotic tendency had already been demonstrated in 379 patients in that they had had thrombosis or embolism, and on 438 abdominal hysterectomies where the statistical risk is great. They report no cases of fatal pulmonary embolism. There were 39 cases (3.9 per cent) of minor bleeding and 25 cases (2.5 per cent) of major bleeding easily controlled with the use of transfusion and large doses of vitamin K. The dosage of dicumarol given was 300 mg. the first day, 200 mg. the second and on successive days according to the prothrombin time, which should be kept between 10 to 30 per cent of normal. They have used the drug for periods as long as three months. Murray[65] reports that following an initial pulmonary infarction, not one of his 45 heparinized patients suffered a fatal pulmonary embolism. Evans[32] of the Lahey Clinic, in a short series of cases, in which he depends mainly on dicumarol (with which he sometimes combined heparin) presents certain advantages for this line of treatment, although it must be admitted that the death of two patients in 56 from hemorrhage should be considered in evaluating this treatment. The advantages of dicumarol are that it is cheap and can be given by mouth. Its action is accumulative for days and this has been a constant pitfall.

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Once the diagnosis of thromboembolism or phlebothrombosis is made there is no dissenting voice except the adherents of the use of anticoagulant therapy as to the treatment that is required. Once an embolus has occurred it is imperative to take steps to prevent further emboli, because of the strong possibility of recurrence. Ziak[100] showed that in 70 per cent of patients with fatal pulmonary embolism there was a previous non-fatal pulmonary infarct, the result of embolism. Only 8.3 per cent of patients die in less than 10 minutes and 33 per cent die in less than one hour of massive pulmonary emboli.[22] Approximately 60 per cent of the patients with fatal emboli live from 1 hour to several days.[23] These figures refer only to the fatal emboli, but it is sufficiently known that only about 1/5 to ¼ of these emboli are fatal at the onset.[5] This allows some time for treatment. In this regard, it is well recognized that the cause of death is widespread radiation of automatic reflexes affecting the heart, pulmonary tree· the bronchi and the gastrointestinal tract. The treatment is emergency ligation of the involved veins. This is not infrequently difficult to detect and certain clinics have resorted to bilateral femoral vein ligation. That this can be done successfully, however, has been demonstrated ably by Fine and Sears,[33] Homans,[42] and Allen and his co-workers.[1] One is impressed by the attempts of various surgeons to preserve the profunda and saphenous veins. That this is dangerous in thrombosis of the veins of the lower extremities is attested by reports of death from subsequent emboli coming from the profunda vein. Homans[44] reports a case where ligation had been done below the profunda and the individual died of an embolus from the profunda. There are two possible sources of accident in case of division of the superficial femoral vein in the leg showing clinical signs of thrombosis; a separate deep thrombosis in the thigh, already present or to occur later, which may give rise to future embolism; there may be a separate, silent thrombosis in the opposite leg. Frykholm[35] has shown that an independent thrombosis frequently starts in the veins of the deep muscle of the thigh, whence it enters the common femoral by way of the great profunda branches. Homans[44] is inclined to think that in old thrombotic processes attended by embolism, one should always divide the common femoral vein above the profunda or even higher. He[44] divides quiet deep venous thrombosis into four main groups, (1) the initial thrombosis in the lower leg develops into a thrombophlebitis and causes the typical swelling of phlegmasia alba dolens; (2) the initial thrombosis remains confined to the veins of the lower leg; (3) the initial thrombosis propagates through the popliteal into the femoral vein and forms a soft floating mass capable of causing pulmonary embolism; and (4) the initial thrombosis propagates through the popliteal into the femoral veins, where it becomes more or less adherent, without causing obstruction, and may come to occupy most of the femoral and external iliac· advancing at times into the common iliac vein and even into the vena cava. He states that most surgeons hold that neither healing nor freedom from embolism are 15 to 1, 25 to 1, or even higher, and they are not justified in withholding a safe, easily performed interruption of the femoral vein. He feels that experience has shown that non-operative treatment is more often followed by recurrence than by a permanent cure, and since embolism is always a threat, an early femoral interruption should be done in all quiet deep venous thrombosis. The question is as to the level of division of the vein. In the type where the thrombus appears limited to the leg, he feels that the point of section should be the superficial femoral vein at the groin just distal to the profunda femoris. Where there is propagation of a deep thrombosis of the calf into the femoral vein in the form of a non-obstructive, non-adherent thrombus, he favors a division of the superficial femoral vein, but if there has been proagation into the common femoral vein, the section should be proximal to the entrance of the profunda. He favors the ligation of the common iliac vein on the basis of anatomical grounds which seem to indicate a better collateral supply. He does not favor bilateral surgical treatment unless there are definite signs to warrant it. He feels that where bilateral ligation is necessary the inferior vena cava should be ligated. This is supported by the work of Collins, Jones, and Nelson[12] who found that following such ligation the venous pressure in the legs is raised only for a short time, for it falls rapidly in the first weeks after operation. They advocated this for thrombosis in the pelvic veins, particularly with additional ligation of the uterine and ovarian veins. Allen, Linton, and Donaldson[1] feel that all cases of venous thrombosis of the lower extremities should be ligated even before there is extension of the process to the femoral vein. Between 1937 and 1943 they interrupted the femoral vein or veins of 202 patients. Bilateral operations, either at the same time or at subsequent dates, bring the total deep veins interrupted to 280. The tremendous increase is partly due to the increased number of bilateral ligations. It seems to make little difference whether the ligation is above or below the profunda but they favor ligating the superficial femoral vein in 75-80 per cent of the cases. Veal and Hussey[93] are of the opinion that in all cases of venous thrombosis there is at some time danger of embolism. They present statistics of 68 cases of venous thrombosis in which pulmonary embolism was not the first manifestation and show that there is no safe period from embolism for at least up to four months. They also present the evidence that usually the emboli are small and raise from fresh clot engrafted on the older, organizing thrombus. They have recently observed at necropsy three examples of death from massive pulmonary embolism in cases of acute iliofemoral thrombophlebitis. In each the embolus originated from a fresh thrombus engrafted on the older clot in the iliac vein. They prefer to ligate at a point just distal to the entrance of the saphenous vein unless there is indication of an extension upward, and then a higher point of ligation is selected. They did 45 cases with ligation of one femoral vein, and six additional patients both femoral veins were ligated at the same operation. The external iliac vein was ligated in only 6 cases although they feel that ligation of the common iliac vein is more desirable. This was due in 29 instances.

In 6 cases it was necessary to ligate the inferior vena cava four times because of thrombosis in both iliac veins, and twice because of extension of inflammation from the left common iliac vein to the wall of the vena cava. It is interesting that, despite their best efforts, in 45 cases in which ligation was performed before the development of pulmonary embolus, there was no instances of this complication, but in 39 cases, in which the operation was done after at least one episode of pulmonary embolus, there were nine cases of postligation embolism. Fine and Starr[33] give the following indications for direct exposure of the iliac (1) swelling of the thigh, (2) pain in the groin and tenderness in the groin or along the upper part of the femoral vein, (3) swelling of the femoral lymph nodes, (4) cyanosis of the thigh, and (5) dilatation of the superficial veins of the thigh. If the femoral vein has been exposed and there is evidence of inflammation, the iliac should then be exposed. Ligation of the common femoral vein is the method of choice in the presence of signs indicating involvement limited to the deep veins below the knee, or if pulmonary embolism had occurred, even in the absence of all signs of thrombosis. They rightly emphasize the necessity of ligating the common femoral vein rather than the superficial femoral vein because of the possibility of pulmonary embolism from the profunda vein, a small portion of which can only be visualized at operation. In a previous report[33] they pointed out that fatal embolism has occurred from thrombosis of the vena profunda femoris when it has been spared by ligation of the superficial femoral vein. If division of the vein is to be done below the head of the thrombus it is important that thrombectomy be done.[51, 52, 53, 70] DeTakats and Fowler[22] are definitely of the opinion that when the patient is seen in the stage where there is a tender swollen thigh or groin, the clot is not to be aspirated nor is the vein ligated above the profunda. Also, if the thrombus is below the knee, but the patient has been ambulatory for more than one week without any extension to the thigh, the veins are not tied for once the clot is organized it has lost its embolizing property.

X-ray has been used in the treatment of intravascular thrombosis as well as sulfanilamide and penicillin.

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The diagnosis of a massive pulmonary embolism is easy with sudden shock and death within ten minutes. Recognition is based on sudden onset of shock with weak pulse, restlessness, difficult, rapid breathing, sweating and pallor, pain in chest, fainting, collapse or unconsciousness. There may be weakness, cyanosis, thready pulse, cardiac arrythmias, and extreme prostration, fall in blood pressure and fear of impending danger. It has been pointed out that only about one-fifth to one-fourth of these emboli are fatal at the first insult.[5] If there is evidence of a massive embolus, one method of treatment that has been tried is the Trendelenberg operation with removal of the clot from the pulmonary artery. Graves[36] reviews 194 cases of pulmonary embolism which were 0.184 per cent of total admittances. The number of emboli occurring in each patient was 1 in 140 patients, 2 in 26 patients, 3 in 19, 4 in 2, 5 in 1, 6 in 1, 8 in 1, and 4 patients had multiple emboli. In the last four patients the emboli were not determinable from history but were found at autopsy. Of the 140 many survived the crisis for hours, and active treatment might have benefited them. In only 45 of the 154 fatal cases did death occur in less than one hour. Fifty-five patients lived from 1 to 24 hours and 47 lived more than one day. The site of lodgment of the embolus was most commonly in the pulmonary branch of the right lower lobe. The site of embolus determined at autopsy showed 68 at the bifurcation of the main pulmonary vessel, 13 on the right and 11 on the left in the main pulmonary branches, 14 in the right upper branch, 16 in the right middle branch and 82 in the right lower, 14 in the left upper branch and 60 in the left lower.

* * *

DeTakats and Fowler[22] feel that there is sufficient time to treat the majority of these patients, first of all for the episode itself, and second for the prevention of a second or third infarct, which might become increasingly dangerous. The patient is immediately placed in a semi-sitting position, oxygen started, atropine sulfate gr. 1/75 given and if this does not cause flushing of the face and dilatation of the pupil this is to be repeated, papaverine hydrochloride ½ gr. is given. They advocate repetition of the atropine and papaverine three or four times a day. The rationale of this emergency treatment is based on the assumption that embolism kills not only because of asphyia, failure of the right heart and insufficient venous return of the left heart. True enough, these conditions prevail when the main pulmonary artery or both right and left branches are simultaneously obstructed. However, it has been shown that patients may die from a small embolus obstructing an insignificant area in the lung.[23] Also, on the basis of animal experiments, it has been concluded that a widespread radiation of autonomic reflexes occurs during embolism, which affects the heart, the pulmonary vascular tree, the bronchi, and gastrointestinal tract.[23] These reflexes are predominantly vagal and produce spasm of smooth muscle; thus the use of atropine and papaverine seems indicated. Morphine and digitalis both sensitize the vagus and thus may facilitate such reflexes. Epinephrine, frequently employed in acute hypertension, may lead to pulmonary edema in the presence of an increased pressure in the pulmonary artery which exists in cases of pulmonary embolism. DeTakats and Fowler[22] state that out of 45 patients reviewed, 35 were relieved of their symptoms and did not die of their attack. Ten patients died and six autopsies were done. These autopsies showed massive arterial obstructions with coils of clots in the right ventricle. Attention is directed to the syndrome of the slowly fatal pulmonary embolism, when death finally occurs from right heart failure many hours or several days after the initial attack. Pilcher[80] suggests the use of embolectomy for this. Robertson[84] believes that if a main pulmonary branch is occluded, findings of pulmonary congestion soon develop in the opposite lung, due to the increased blood flow. There may be evidences of acute dilatation of the right ventricle, peripheral venous dilatation, and sometimes pulsation may be noted. This is usually associated with marked accentuation of the second pulmonic sound due to increased pulmonic pressure. The x-ray diagnosis is disappointing. The wedge shaped infarct is the great exception,[38] and it should be remembered that not all emboli produce hemorrhagic infarcts; anemic areas may be translucent; areas of atelectasis or emphysema may be visible, depending on the extent of bronchial obstruction. Pleuritic effusions, embolic atelectasis, and embolic pneumonias may mask the origin of the lesion. DeTakats and Fowler[22] used adequate heparin-dicumarol therapy in 31 patients with no reduction in the size of the pulmonary infarct.

In a review of nine cases of non-fatal pulmonary embolism seen recently at the DeWitt General Hospital, two of which were personally observed during an embolism, one is impressed by the frequent diagnosis of pneumonia. It is of interest that although each one experienced a major embolic accident, they all survived, although only four cases were treated with vein ligation, one iliac, two common femoral and one superficial femoral.

REPORT OF CASE

Case 1.—Case Report—O. B., age 22, appendectomy Feb. 28, 1945, spinal anesthesia, for acute appendicitis. Patient had an upper respiratory infection postoperatively, requiring penicillin. He experienced a severe pain in the right chest with hemoptysis seven days postoperatively. He was treated with morphine, oxygen, and intramuscular penicillin, but continued to expectorate bright red blood. Portable x-ray film demonstrated no pulmonary pathology. Repeated examination showed nothing except a temperature of 100, pulse of 100, and respiration of 24. The possibility of a pulmonary embolus was entertained, but there were a good many signs of pneumonic reaction and no changes in the extremities. He finally showed plantar pain and tenderness followed by tenderness in the calf of the leg pain on dorsiflexion of the foot. Right common femoral vein ligation without division of any venous tributary was done two weeks after the first embolus, because of the signs of propagating thrombosis. Heparin was given continually for four days postoperatively. This was followed by recovery from the pulmonary condition. Repeated measurements have shown no edema of the extremity, and this has been helped by the use of a supportive bandage.

This case is reported because it presents a typical case history. It also shows the necessity for close observation of these cases in which an embolus occurs and phlebothrombosis is suspected.

* * *

It has been repeatedly observed by us that if careful observation of the case is made once the diagnosis is suspected, early detection of a propagating thrombus can be made and adequate treatment instituted. As has been previously stated the initial embolus is rarely fatal, and it is felt that it is not necessary to do bilateral venous ligation on suspicion only. Careful observation has disclosed increase in size of the extremity, plantar or calf tenderness, and tenderness along the course of the deep veins. An additional factor was introduced in this case which consists in the use of an anticoagulant following the vein ligation. It has been noted, in the observation of 42 cases of deep venous thrombosis of the lower extremities, that the degree of lymphedema varies with the extent and site of the thrombus. The more the extent and the more central the thrombus, the greater is the lymphedema. It is extremely important to limit the extent of the thrombus so as to preserve all possible collaterals. Ligation of a vein certainly will favor propagation of a thrombus by stasis in the ligated segment. This should be prevented by the use of anticoagulants. This will be discussed in detail subsequently under the heading of lymphedema. We have also noted that the condition can and does occur frequently in young individuals with equal distribution as to the extremities involved. In all cases the condition was heralded by an embolism. They have been observed from periods of 3 months to 18 months with no recurrence of their thrombosis or embolism. This is adequate proof that not all individuals are prone to recurrence. The problem of edema that all the cases presented will be discussed subsequently.

* * *

ACUTE DEEP THROMBOPHLEBITIS

The problem of acute deep thrombophlebitis has been deliberately excluded from the discussion to this point for it is felt that it has no bearing on the problem of thromboembolism as discussed. Despite stated opinions to the contrary,[31, 93, 97] it is felt that there is a fundamental difference between acute deep femoroiliac thrombophlebitis and quiet deep venous thrombosis, phlebothrombosis. It is the conviction of Ochsner and DeBakey,[69, 71, 72, 73] and this is concurred by Homans,[42] that from etiologic, clinical, prognostic, and therapeutic standpoints, it is necessary to distinguish between these two major types. The clotting in thrombophlebitis is the result of injury to the vascular endothelium from mechanical trauma, chemical injury, or bacterial invasion, whereas in phlebothrombosis the intravascular thrombus formations are due to alterations in the cellular and fluid consttiuents of blood, which increase the clotting tendency, and to venous stasis. The clinical manifestations of the two types of intravenous clotting are entirely different. In thrombophlebitis, the symptoms are marked, whereas in phlebothrombosis there are few, if any clinical manifestations. The prognostic significance of this differentiation lies in the fact that in thrombophlebitis, unless there is suppuration, which is rare, the clot is firmly adherent to the vein wall and therefore is not likely to become detached and result in embolism. Because of the associated inflammatory process, it is usually accompanied by profound arterial spasm resulting in edema which may persist and cause prolonged disability. On the other hand, the coagulum in phlebothrombosis is loosely attached to the vein wall and can be detached easily, resulting in embolism. The therapy of the two conditions is also different. Because the clinical manifestations in thrombophlebitis are due to associated vasospasm, the relief of vasospasm usually results in prompt relief of symptoms. On the other hand, in phlebothrombosis, either thrombectomy or the ligation of the vein above the thrombus is imperative in order to prevent a possible fatality from pulmonary embolism. The vascular changes in thrombophlebitis can be divided into those occurring in the perivenous tissue and those in the vein wall itself. The perivenous changes consist principally of a lymphangitis According to Koester[50] the thrombophlebitis process is in reality a lymphangitis of the veins in which the infection is carried to the veins by means of lymph channels. The importance of the perivenous lymphangitis has been emphasized by Karsner.[49] Homans,[46] Homans and Zollinger.[45] As a result of the perivenous involvement, fibrinous exudation into the perivascular spaces and the accumulation of perivascular fluids resulting in edema are likely to occur. In addition to the perivenous changes there are changes within the wall of the vein, consisting primarily of hyperemia, cellular and serous exudation, and a destruction of endothelium, which is probably responsible for the thrombosis. The intravascular changes which occur in thrombophlebitis consist of the development of thrombi. The clot or thrombus produced in thrombophlebitis differs from that produced in phlebothrombosis in that the former is attached to the vein wall. There also becomes adhered to the vessel wall in this area, leucocytes and fibrin, resulting in a white thrombus. This is different from the red or coagulation thrombus which occurs in simple intravascular clotting. The white thrombus because of destruction of the vascular endothelium is firmly attached in contrast to the red thrombus which is loose, detaches easily, and can cause pulmonary embolism.

* * *

The clinical picture is a consequence of the inflammatory reaction within the vein wall and the associated vasospasm resulting from impulses originating in the thrombophlebitic segment; there is diminished vascularity with pain, swelling and persistence of fever. There is pain in the region of the involved vein, and swelling of the involved extremity. The classical picture of deep thrombophlebitis is phlegmasia alba dolens, in which the pyrexia ranges up to 103° F, associated with severe pain and swelling in the involved extremity. The fever is probably due to the inflammatory reaction within the vein wall. DeBakey and Ochsner[70] have demonstrated that the pain is due to ischemia, as evidenced by the prompt relief following the reëstablishment of the normal blood supply to the extremity by blocking the sympathetic impulses. The edema was previously thought to be due to increased venous pressure resulting from the obstructing thrombus in the main vessel but Ochsner and DeBakey[69,71,73] have shown clinically, and DeBakey, Burch and Ochsner[16] have shown experimentally, that the edema is secondary to severe arteriolar spasm in the extremity resulting from the vasoconstrictor impulses originating in the inflamed segment which are carried over the sympathetic nervous system. This vasoconstriction is responsible for the whiteness of the skin as noted, in phlegmasia alba dolens. This results in anoxia of the capillary endothelium, and thus increased permeability, resulting in excessive exudation of fluid into the perivascular spaces and resultant edema. Once the fluid gets out of the vascular system there is difficulty in its getting back for two reasons: first, absorption is interfered with because of the increased venule pressure resulting from venule spasm; and second, the pump which is responsible for the movement of lymph—namely, arteriolar pulsation is lost.[78] There is no danger of embolism unless there is a secondary upward propagation of the thrombus, and this is usually clinically detectable.

Since there is vasospasm in cases of acute thrombophlebitis, this should be overcome. The best method of producing vasodilatation is the interruption of the sympathetic impulses by anesthetization of the regional sympathetic ganglia by procaine. DeBakey, Burch and Ochsner[16] were able to demonstrate graphically that in thrombophlebitis there is a marked spasm of the arterioles and venules of the extremity. There is some spasm of the contralateral arterioles. Following the procaine block the arteriolar pulsations return to normal, relief of pain is immediate and may not recur. In approximately 90 per cent of the cases[67] the pain does not recur after the first block. In the remaining cases, however, a second injection is required to relieve the patient permanently of pain. Fever and edema disappear rapidly. The temperature returns to normal within 48 hours in about 65 per cent of the cases. In about 5 per cent of cases the pyrexia lasts longer than eight days. The swelling of the extremity, instead of lasting for months and even years, subsides very quickly with the reëstablishment of normal blood supply. In Ochsner and DeBakey's cases[68] complete subsidence of edema occurred within four days or less after treatment was begun in 50 per cent of the cases, and within 5 to 8 days in 30 per cent. In only two patients did edema last as long as 12 days. Two-thirds of the patients were discharged from the hospital on the 4th to 8th day after treatment was begun and 23 per cent from the 10 to 12 days. In follow-up lasting from 2 years to 6 months there was no recurrence of the edema.

* * *

The technique of lumbar sympathetic block is simple and the results effective in the presence of extreme vasospasm as occurs in acute deep thrombophlebitis. Ochsner and DeBakey[72] agree with Leriche and Kunlin[54] that even repeated sympathetic blocks may be required. Ochsner and DeBakey[72] recommend one injection every 24 hours until the individual is fever free. The individual is placed on his abdomen if possible with a pillow underneath so as to straighten the lumbar curve. The lateral decubitus position may be used. The skin is prepared with ether and merthiolate. The crest of the ilium is identified and the 3rd lumbar interspace then located. The spines of the 2nd, 3rd and 4th lumbar vertebrae are then located and skin wheals of procaine placed approximately 2½ finger breaths lateral to the upper part of the spinous process (about 4½ to 5 cm.) 13 cm. (5″) long No. 20 gauge needles are then slowly inserted through the muscles underneath injecting procaine as the procedure is done until the transverse spinous process is struck. This point is important as the sympathetic ganglia lie in a plane about 2½ finger breaths deeper (about 4-5 cm.). This point is then noted on the needle and the needle is partly withdrawn and reinserted in a plane slightly anterior to the transverse process and toward the midline until the body of the vertebrae is felt or until the point noted on the needle is reached.

Sometimes a branch of the lumbosacral plexus is struck with resultant radiation of pain down the extremity and if this occurs the direction of the needle is changed slightly. After careful aspiration to insure against intravascular injection, 10 cc. of 1 per cent procaine hydrochloride solution is deposited in each site. If no block is affected 5 cc. more are injected. This is effective in a high percentage of cases. It is felt unnecessary to insert a needle in the first interspace as effective block has been repeatedly noted without doing this. It is important to do effective block each time and to use a minimum number of needles as this procedure even under the best of circumstances is not entirely pleasant. It is important to obtain effective block in all three needles. There are certain complications which have been observed such as striking a vessel, referred pain along the lumbosacral plexus and temporary anesthesia in distribution of the lumbosacral plexus, pain along the distribution of the genitofemoral nerve, vasomotor collapse and inadvertent intraspinal anesthesia. Each of these can be averted with care and if properly evaluated corrections can be made so that future blocks are effective. The most common error is the use of too short a needle with resultant anesthesia merely of a portion of the lumbar plexus. This can easily be obviated by deeper injection.

* * *

CHRONIC LYMPHEDEMA SECONDARY TO INTRAVENOUS THROMBOSIS

It is felt propitious at present to discuss the problem of chronic lymphedema caused by venous obstruction. One is not entirely impressed by repeated statements that all cases suspected of phlebothrombosis should be treated by vein ligation before clinical signs are evident. That this can be done successfully, however, has been ably demonstrated by Allen, Linton and Donaldson.[1] This presents a serious complication when it is noted that in 62 patients (47.4 per cent) without infarcts, no thrombi were found at operation. Chronic lymphedema is a serious disability and is not lightly to be regarded. I wish to particularly emphasize the golden period of treatment of these conditions which if not vigorously pursued are unsuccessful and allows the disease to come to the undesirable sequela of edema. This is practically impossible to cure when fixed despite sporadic reports in the literature to the contrary. The treatment used should not only spare life but should also prevent morbidity in the form of persistent edema. This is especially true where ligations are done. It is these cases that demonstrate marked incapacity and persistent disability. Ligation of major veins is not an innocuous procedure. It is of interest, however, that mere ligation does not cause permanent edema but that the associated thrombus does, particularly if extensive. Another consideration is the development of secondary varicosities. These have been treated successfully by ligation by Buxton, Farris, Moyer, and Coller.[10] If this was not successful femoral vein ligation has been done. At this vascular center we have adopted a conservative course of treatment consisting of elevation of the bed to 40° with absolute bed rest until the edema subsides and then dependency with the use of elastic supportive bandages. The individual is educated to the condition he has and is definitely instructed as to decreasing periods of rest period and the necessity of rewrapping elastic supports after each elevation and at least three times daily. We have not been favorably impressed with the use of the elastic stocking.

* * *

In a review of 9 cases of phlebothrombosis, 33 cases of deep thrombophlebitis, and 7 cases of axillary thrombosis it is noted lymphedema was present in all but 2 cases. In 34 cases of deep thrombophlebitis seen in the chronic stage, the duration varying from 2 months to 24 years, one is impressed by the disabling presence of lymphedema. This was frequently not incapacitating but was certainly disabling. Of this number 10 were treated with repeated lumbar sympathetic ganglion blocks in the acute stage and all had lymphedema despite dramatic relief from the blocks. The edema increased on dependency and on activity. The diagnosis in all ten was confirmed by phlebography. It is felt that as far as edema in the late stage is concerned variations of early treatment seemed without effect. It was thought that possibly lumbar sympathetic ganglia block in the late stages might be of help and this was used in 16 cases, but this had no particular effect except in one case it was felt that such a successful test was adequate reason for a lumbar sympathectomy, but this proved ineffective in reducing the edema. The sympathetic ganglia blocks were effective in improving the color but had no effect on the extent of the edema or comfort. We are increasingly of the opinion that the prevention of lymphedema, after active spasm has subsided, by the use of supportive elastic bandages is necessary every time the extremity is dependent. The time to treat the lymphedema is in its very beginning with active therapy and particularly the use of elastic supportive bandages for 6 months or longer.

* * *

We have long sought a means of detecting a tendency to thrombosis before it occurs. Interest in preventing excessive coagulability of the blood has risen since the advent of coagulants but this must necessarily be on an empiric and statistical basis. In order to use such drugs preventively and not only therapeutically, it is necessary to use a simple diagnostic test. Repeated determinations of bleeding and clotting times (Lee & White) in 65 cases revealed no changes in the acute stage. The same is true of the usual prothrombin time determinations but prothrombin time determined on diluted plasma does detect a tendency toward increased clotting but the method requires skilled laboratory technique.[8] Estimation of the erythrocytic sedimentation rate has been of considerably more value and is used as an index of activity. The response of such patients to heparin is strikingly diminished and this decreased heparin tolerance has been used extensively for determining the increase in clotting factors. Such factors have been known to exist in the postoperative state, in Buerger's disease, and in the presence of any kind of intravascular clotting by DeTakats.[19] Other factors such as neurogenic influences[20] and the thromboplastic properties of digitalis[25] have been investigated. Conversely, drugs like prostigmine[20] or sulfa compounds[18] seemed to decrease the increased clotting factors. It has been used to determine the heparin response of such patients who were either suspected of harboring thrombi or who have shown previous evidence of thrombosis by DeTakats and Fowler.[22] 1 cc. (10 mg.) of heparin is injected intravenously. Coagulation times are determined with a capillary tube before, and 10, 20 and 30 minutes after the injection of heparin. They report that a flat tolerance curve indicates the presence or imminence of thrombosis. The normal response can be restored by heparin, by dicoumarol by sulfur compounds, or by prostigmine.[18, 19, 20, 22] We attempted to test the validity of the determination in 6 cases and found no conformity of the heparin curve to the clinical condition. We modified the test by using the Lee and White method of clotting time.*

Cases 1 and 3 were cases of superficial phlebitis in the active stage who showed a maximal rise and this was true of case 2, an acute Buergers disease, and case 4 which was in the active stage of repeated superficial thrombosis as well as a subsequent episode of acute deep thrombophlebitis. Cases 5, 6 and 7 were also active cases of superficial thrombophlebitis where there appeared to be better correlation of the erythrocytic sedimentation rate. We are unable to use the method effectively.

* * *

AXILLARY THROMBOSIS

We have collected seven cases of axillary thrombosis in individuals varying from 20 to 37 years of age. The causes were from mild to severe and as follows: climbing a rope, throwing rocks, twisting a propeller, spontaneous, carrying buckets, and playing tennis. Other causes that have been reported are grinding spark plugs, stirring clothes while washing, pulling oneself up by holding on to the head of the bed, checking and restraining a horse, swinging a golf club, pitching a baseball, lifting a heavy pressing iron, lifting a cake of ice, lifting a storage battery out of a car, and putting books on a shelf.[48] From this it is suggestive that some sort of a strain is necessary for its production. The right arm was affected in five instances and the left in two. The onset varied from acute involvement to gradual swelling. Pain experienced in the arm is usually followed by swelling and cyanosis which may require several hours or days to develop after the strain. The diagnosis in all cases was confirmed by phlebography which shows a typical venous pattern of obstruction of the axillary vein. There is associated arterial spasm in the early stage, with the hand being colder, and this is best treated with stellate gangloin block repeated until the pain and edema subside. We have used the anterior approach exclusively because of the ease of performance and the facility with which it can be taught. The method is that described by Ochsner and DeBakey.[74] The individual lies on his back with the head turned to the opposite side. However, instead of selecting a point 1 cm. medial to the midpoint of the clavicle merely the midpoint of the clavicle is selected and intracutaneous wheal made immediately over the upper border of the clavicle. A fine lumbar puncture needle (No. 22 gauge) is introduced on a horizontal level with the clavicle and directed posteriorly and medially at a 45 degree angle with the midline. The point of the needle after being introduced for a distance of 6 to 7 cm. impinges against the anterolateral surface of the body of the seventh cervical vertebra, or at the junction between the seventh cervical and the first thoracic vertebra, where the stellate ganglion lies. After ascertaining by aspiration that the needle is not in a vessel 10 cc. of 2 per cent procaine is injected. A satisfactory injection is determined by the presence of Horner's syndrome, anhydrosis and an increase in warmth of the extremity on the injected side. These injections are repeated every 24 hours until complete relief is experienced. The procedure is not entirely innocuous and some observed complications which are not severe have been chylopneumothorax, pneumothorax, aspiration of blood from presumably the vertebral artery, and aspiration of spinal fluid. As experience increases these do not occur. The individuals, however, are subject to pneumothorax, and any pain along the shoulder or anterior chest should be investigated with x-ray. With proper treatment the edema subsides but soon there is increased prominence of the superficial veins about the shoulder. Several theories have been advanced for the cause of this condition. Von Schrotter[96] who first described the entity in 1884, maintained that the stretching of the muscle stretched the axillary vein and caused a localized reaction and thrombosis. Cadenat[11] believed that the respiratory effort that was associated with strain distended the vein and produced a change in the intimal lining of the vessel leading to thrombosis. Lowenstein[56]

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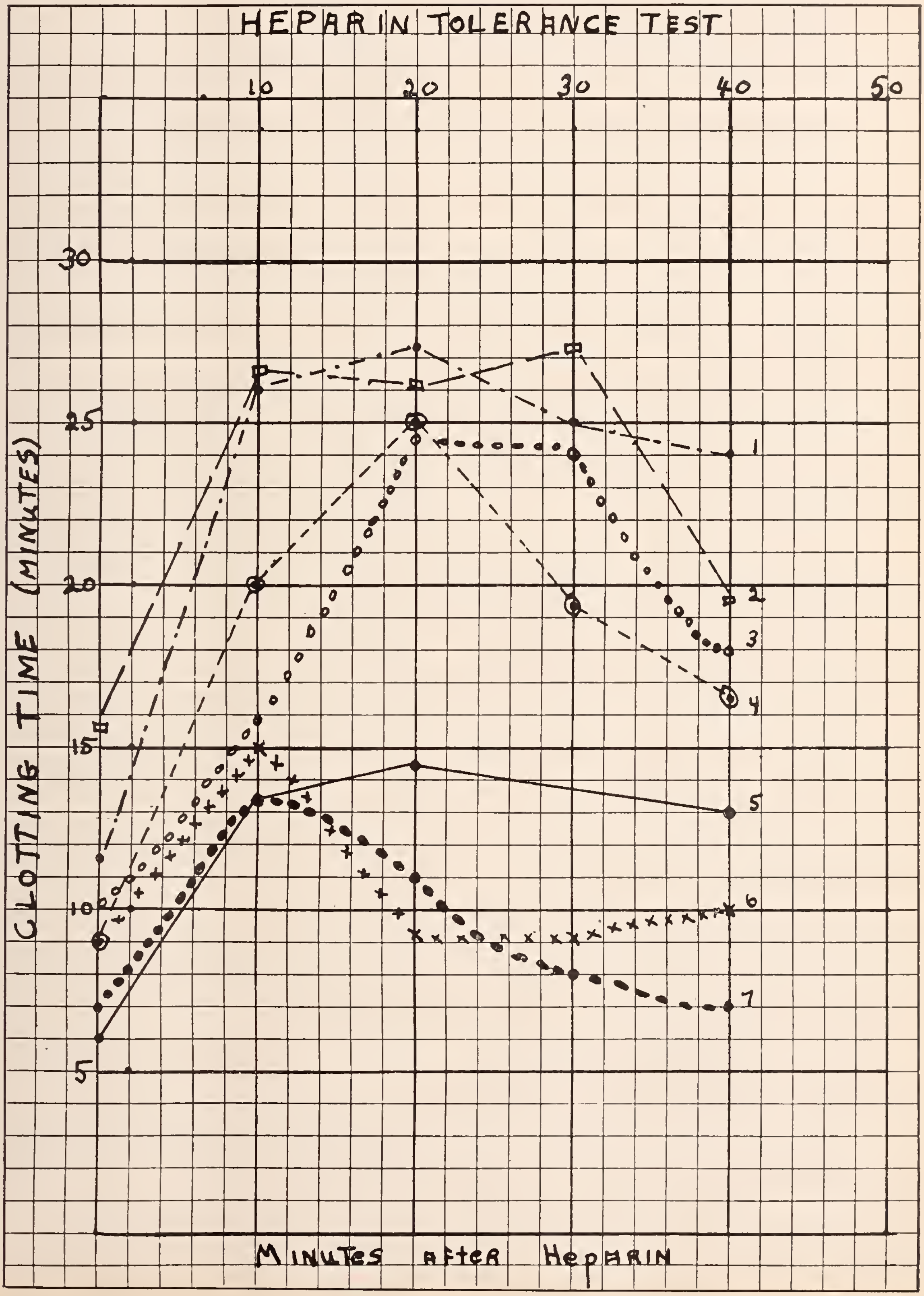
* These were performed by Lt. Jack D. Davidson.



contended that holding the arm in the abducted position distended the axillary vein and caused the costocoracoid ligament and subclavius muscle to indent it. This distention plus pressure upon the vein was sufficient to produce thrombosis. Gould and Patey[37] confirm these findings, and in addition, demonstrated a valve present at the level of the subclavius muscle which ruptured following pressure by the muscle on the axillary vein. Veal and McFetridge,[94] on the other hand, held that the thrombosis was due to a compression of the vein below the head of the humerus against the subscapularis muscle. These theories do not explain the quiet type of thrombosis without apparent cause. It may be that when thrombosis develops during sleep it is probably caused by a prolonged compression of the vein induced by the position of the arm, particularly when it is elevated over the head or folded under the body. This obstructs venous flow, reduces oxygen content of the blood with intimal changes, and results in thrombosis.[91] It is also difficult to understand the failure of these upper extremity thrombosis to produce pulmonary emboli.

Of the seven cases seen at De Witt General Hospital 1-12 months after the acute involvement all presented edema, slight cyanosis and prominent collateral veins about the shoulder. The venous pressure was uniformly elevated and the circulation time prolonged on the affected side. In each case phlebography confirmed the diagnosis of axillary obstruction. They were treated with extreme elevation and repeated sympathetic block without marked change. It is emphasized that the early adequate treatment is the most important in the prevention of the lymphedema which is so disabling.

De Witt General Hospital.

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X-RAY EXAMINATION OF THE CHEST IN A COUNTY HOSPITAL*

ROUTINE EXAMINATIONS IN A COUNTY HOSPITAL IN CALIFORNIA

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San Luis Obispo
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Santa Barbara

No one questions today the importance of the routine x-ray filming of the supposedly healthy chest. In the diagnosis of pulmonary tuberculosis and in other unsuspected non-tuberculous[1] lesions of the chest the film is supreme. What seems amazing now is that existing facilities have not been utilized these past twenty years since x-ray has been recognized as the only diagnostic technique worthy of the name in evaluating pulmonary lesions. Year after year the x-ray facilities of hospitals, private and tax-supported, stood idly by while the anti-tuberculosis campaign ground on slowly, emphasizing other means of approach for the most part. In a recent communication the president of the California State Tuberculosis Association, Dr. Howard W. Bosworth[2] of Los Angeles said in part, "The Public Health people had the right idea—every one must be x-rayed."

Enough time has elapsed to have many evaluations of the tremendous effort by the Selective Service System and the Tuberculosis Control section of the United States Public Health Service. In recent months every journal adds additional information. Millions of films have been taken and the most valuable feature of the effort has been the sharing of the knowledge gained from the films; this information has been returned to the Public Health Department of the home county from which the selectee had come, in case of his rejection. A huge central file pooling this information should be established for use by local Public Health Departments.

WHY HOSPITALS SHOULD MAKE ROUTINE X-RAY CHEST EXAMINATIONS

There are many reasons why every hospital[3] should routinely x-ray every admission to its wards. Some of the benefits accrue directly to the hospital that protects its nursing staff[4] from contact with undiagnosed open cases of tuberculosis which in some hospitals comprise from one to five per cent of all entries. Compared with other contagious diseases, the presence of undiagnosed tuberculosis in patients hospitalized for reasons other than tuberculosis, seems hardly pardonable. One does not need to imply that all of a patient's disabilities "from the cradle to the grave" should be diagnosed at the time of one hospital admission. But it does seem reasonable to ask if a most highly infectious, communicable disease should not be diagnosed in an institution where facilities exist for x-raying at nominal cost. To protect the nurses in attendance and the unsuspecting public from which he or she came, as well as to diagnose a lesion early rather than late, seems wise and economical. Most hospitals have routine films on their nurses to protect the patients from pulmonary tuberculosis. Is it fair to ask less in return from the newly hospitalized patient?

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Compared with routine blood counts, blood Wassermanns, and urinalyses, for the diagnosis of blood dyscrasias, syphilis, and renal pathology, a single routine P.A. film of the chest has been proven to yield a much higher percentage of evidence of pathology many times over. Then, why not a routine x-ray film in all hospitals?

Each year of sanatorium care per patient at a minimum cost of $1,500.00 per annum, if saved by this method, should buy many films or pay overhead, even if 14x17 films were used as in cases here presented. The San Luis Obispo Tuberculosis Association contributed $1.00 per single chest film, the San Luis Obispo County Hospital budget absorbed the balance of the expense.

STUDIES AT SAN LUIS OBISPO COUNTY HOSPITAL

The following survey attempts to show how a County Hospital can be utilized in tuberculosis case finding. Three different groups are described and the results of x-ray examinations compared.

The first group comprises 409 patients who were treated at the General Hospital during the experimental two-year period. A chest film (14x17) was taken routinely on every patient admitted for the first time as in- or out-patient.

The second group comprises all patients who were seen in the Chest Clinic during the same period. The Clinic was conducted by Dr. Arthur Bruce Steele in collaboration with the Staff of the Health Department. A total of 342 patients were seen.

The third group comprises 2,561 persons who volunteered for chest x-rays (4x5) taken by a mobile unit supplied by the California State Tuberculosis Association. The mobile unit remained in this county for one week during May, 1944, and was stationed in a different community each day.

Thus, the first group shows the incidence of tuberculosis in patients who came to the hospital due to some sickness, usually not connected with their chest; in this group only patients eligible for county service, roughly the lowest socio-economic third, were seen. The second group shows the incidence of tuberculosis in patients who are either known contacts of tuberculous individuals, or who themselves showed symptoms suspicious of chest pathology. The third group, comprising volunteers for the mobile x-ray unit, responded to publicity soliciting coöperation in a mass x-ray survey, appealing to their good citizenship and foresight.

It could be anticipated that the greatest number of cases of active tuberculosis would be found among the chest clinic clientele, somewhat fewer among the county hospital patients, and the smallest number among the "healthy" general population. (See Chart 1.) The following figures are a graphic confirmation of this supposition:

RESULTS

(1) Cases showing no evidence of past exposure to tuberculosis:

This group is represented by only 24 per cent of chest clinic patients, 26 per cent of county patients, and 48 per cent of mobile unit volunteers. In the chest clinic sample only 29 per cent of children under 10 years showed no signs of past exposure to tuberculosis, compared to 54 per cent in the same age group among county patients and 79 per cent of the mobile unit; the ratio of unexposed cases within each decade for each of our three groups is illustrated in Chart 2.

(2) Cases showing evidence of exposure to tuberculosis:

(a) Cases showing evidence of healed primary complex: Chest Clinic 47 per cent, county patients 59 per cent, mobile unit 49 per cent; again taking children up to the age of 10 years as indicators, we find that already 43 per cent of the children in the chest clinic showed healed primary complex, while only 36 per cent of county patients, and 20 per cent of mobile unit children have been so exposed by the time they reach their 10th year.

(b) Active primary complex was found in 4 per cent of chest clinic patients, 1 per cent of county patients, and none among mobile unit volunteers. Practically all these occurred in children under 10, constituting 25 per cent of

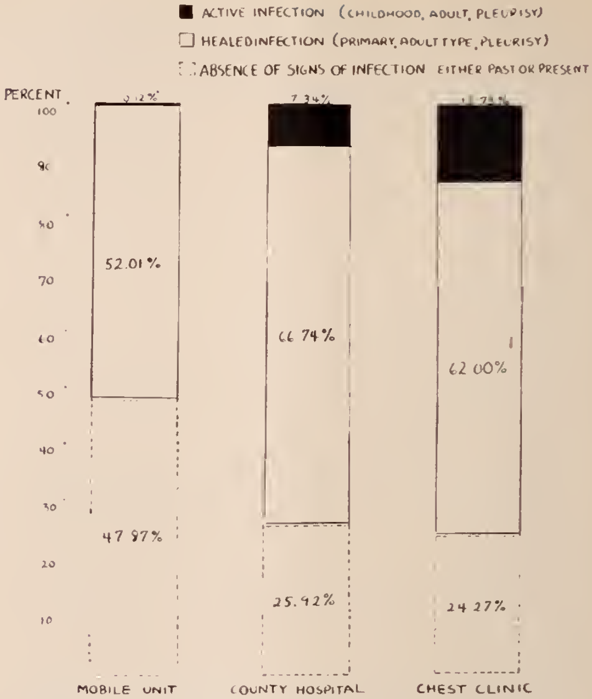

Chart 1.—Comparison of uninfected, healed infected, and active case incidence in three groups.

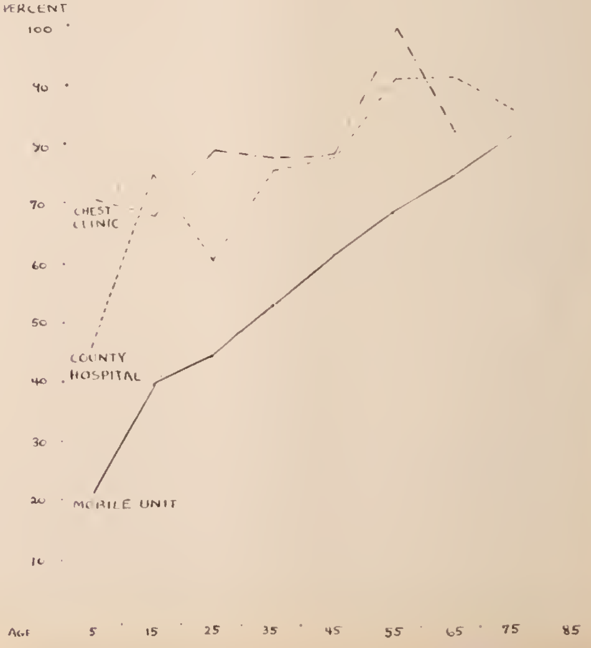

Chart 2.—Ratio of age of exposure to tuberculosis in three groups.

children examined in the chest clinic and 10 per cent of children among county patients.

(c) Healed re-infection type tuberculosis was found in 13 per cent of chest clinic patients, 5 per cent of county patients, and 3 per cent of mobile unit volunteers.

(d) Active re-infection tuberculosis was found in 8 per cent of chest clinic patients, 5 per cent of county patients, and 0.12 per cent of mobile unit volunteers. The overall rate by age is given in Chart 3.

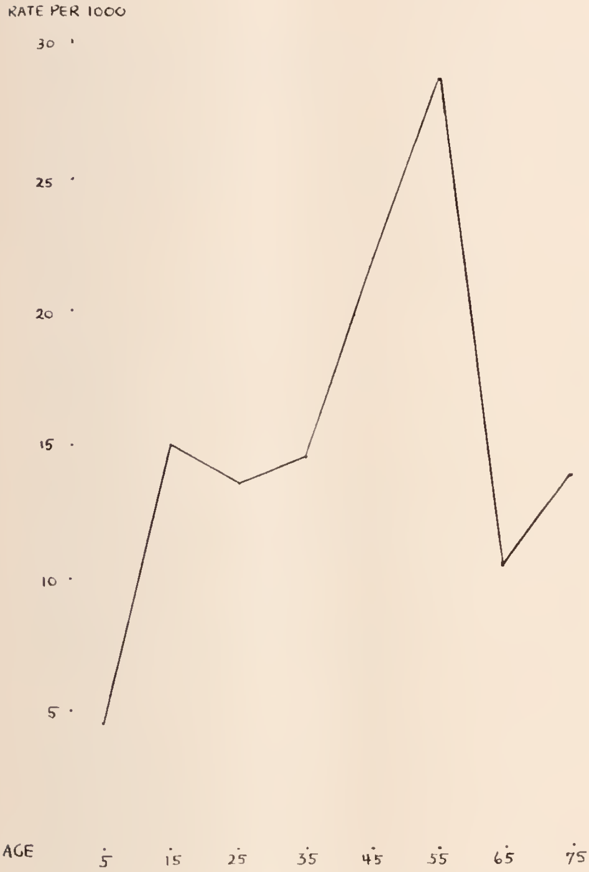

Chart 3.—Overall rate of active tuberculosis according to age.

An additional number of 468 chest films were taken during the experimental period; the group covered comprise all teachers of the county school system, all employees of the General Hospital and Tuberculosis Sanatorium, women attending the Pre-Natal Clinic, and some NYA workers. These groups in addition to the experimental groups discussed previously comprise a total of 3,780 cases. From this total 53 cases of active pulmonary tuberculosis were found. Of these 21 were derived from routine hospital admissions.

Example.—Inclusion of a chest film in every routine examination at a general hospital seems to be worthwhile *only* if this is done in every case regardless of history or clinical status. A man who had been previously hospitalized in various Los Angeles hospitals for a number of non-pulmonary complaints was brought to the San Luis Obispo General Hospital by the police who had picked him up for inebriety and asked that he be kept in custodial care over-night. A routine x-ray film of his chest revealed far-advanced active pulmonary tuberculosis.

SUMMARY

(1) Routine 14x17 x-ray films of the chest were taken at a county hospital in California for a two-year period on all admissions including dispensary from June, 1942, to June, 1944.

(2) The costs were defrayed by the County of San Luis Obispo Tuberculosis Association and the tax-supported county hospital.

(3) The results fully justify the money spent in that many hitherto undiagnosed tuberculosis cases were found, 21 cases from 409 chest films. In addition much non-tuberculosis chest pathology was discovered. (Not reported.) The program will continue until the procedure fails to be economical, i.e., until the cost per discovered case is too high.

(4) In the material surveyed the incidence of pulmonary tuberculosis would appear to be highest among contacts with known cases of open tuberculosis; secondly, among people seeking hospitalization for other reasons, and thirdly the general population.

(5) It would appear that standard films in hospitals on all entering patients is not only good medical practice but good public health.

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CLINICAL NOTES AND CASE REPORTS

SJORGREN'S SYNDROME-TREATED WITH STILBESTEROL

REPORT OF CASE

Lt. Comdr. Benjamin Friedman (MC), (S), U.S.N.R.
and
Commander Henry Gernand (MC), (S), U.S.N.R.
Los Angeles

SJORGEN'S syndrome is a clinical entity characterized by dryness of the mouth, nasal passages, upper respiratory tract, genital tract, dryness and irritation of the eyes, and arthritis. The eyes present lesions which are included under the heading of keratitis sicca. The disease occurs almost exclusively in women, usually at the time of menopause, and is often aggravated during menstrual disorders. The etiologic basis is presumed to be a deficiency of the female hormones, and this presumption is sustained by a number of cases which have been reported, and successfully treated with the female hormones.

Keratitis sicca, as the name implies, is associated with deficient tear formation, a phenomenon which can be readily ascertained by inserting a narrow strip of filter paper into the lower conjunctival fornix and noting the extent to which the paper has been wetted in a given length of time (Schirmer's test). The cornea usually presents punctate erosions of the epithelium; these stain best with rose Bengal. The bulbar conjunctiva characteristically takes the stain in the form of a rose-colored triangle on either side of the cornea. The corneal epithelium may desquamate in shreds (keratitis filamentosa). These patients are usually first seen by the ophthalmologist because of the ocular distress.

Report of Case

Case 1.—Mrs. E. J., age 42, was seen in the eye clinic on December 6, 1944, complaining of burning and pain in both eyes, particularly the left. The lids felt hot and dry. There was no tearing, no photophobia, and no secretion. These symptoms had existed for three years, with occasional brief remissions. Just prior to the menstrual periods the complaints were intensified. The nose and throat were dry, and the voice was often hoarse. She had noted white patches on the mucous membranes of both cheeks ten years previously; they were attributed to the prolonged use of antiseptic lozenges. Similar lesions had arisen on the left side of the tongue eighteen months ago. The tongue at times was painful. There were patches of psoriasis on the body. The left thumb had been swollen and painful during the previous winter. The menses had always been painful, and excessive in amount, but had been otherwise quite normal. However, the current menstrual period was already delayed and was subsequently missed. The classical picture of keratitis sicca was evident. The pateint had been under the care of ophthalmologists since the onset of symptoms, but had failed to respond to the usual prescriptions of salves, eye drops, and vitamins.

The gynecologist (H. G.) reported the following findings: Vulva hypoplastic. Vaginal vulvar and cervical mucous membranes are pale and thin. Corpus uteri studded with nodular subserous fibro-myomata. The skin of both thighs was marked with numerous striations resulting from ruptured elastic fibers.

Laboratory data were essentially negative, and included Kahn tests, blood counts, and dental examinations. There was no obvious explanation for the leukoplakia; the patient herself thought they had followed the prolonged use of "sucrets" some ten years previously. Histologic examination of a biopsy specimen revealed findings characteristic of leukoplakia. Cultures taken from the conjunctival fornices proved to be sterile.

Treatment was begun with high dosages of Vitamin "B" administered by mouth, and later intravenously. No improvement resulted in the objective ocular findings or in the oral lesions. The dryness of the eyes, the transient blurring of vision from epithelial changes, and the annoying dryness of the mouth persisted unabated. During one exacerbation, the vision of the right eye was reduced from 20/20 to 16/20, while that of the left eye fell to 10/20. At this time, long shreds of desquamated epithelium hung from both corneal surfaces. An uncomfortable dryness of the vaginal tract was experienced.

The patient was referred again to the gynecologist for more specific gynecologic treatment. He prescribed stilbesterol in daily doses of 1 mgm. After the fourth day, the patient noted marked symptomatic relief. Stilbesterol was continued in the same dosage for one month. A definite improvement was noted in the appearance of the leukoplakia. It was felt inadvisable to increase the dosage at this time on account of the uterine fibroids. On February 20, 1945, a sub-total hysterectomy was performed. At operation both ovaries were found cystic and scarred to an extreme degree; the right one being almost completely atrophic. Stilbesterol was continued during convalescence, and the patient remained symptom free, but she failed to take stilbesterol while at home, with the result that the ocular discomfort returned and the oral lesions again grew larger.

On resumption of stilbesterol, in increased dosage of 3 mgm. daily, combined with 100 mgm. cevitamic acid, the oral lesions disappeared within two months. The patient's maintenance dosage of stilbesterol is apparently 3 mgm. per day, for if she takes less than this amount her ocular discomfort returns and the corneal lesions reappear. As long as the dosage is maintained she feels comfortable and there are only occasional corneal lesions visible. The administration of stilbesterol in this case can be considered only as affording palliative relief, without permanent cure, just as insulin cannot be expected to cure diabetes but is effective as long as it is used.

1930 Wilshire Boulevard.

The Social Aspects of Medicine

The following by Edwards A. Park, M.D., is from an article in the official journal of the American Academy of Pediatrics. Dr. Park is pediatrician at the Johns Hopkins Hospital, Baltimore.

Quotation follows::

All thoughtful people are conscious that great changes in the organization of society the world over are in progress. These had been developing obviously enough prior to the outbreak of this present war, but the war with its loosening and stirring up processes has undoubtedly intensified their progress.

We are in the beginning of a great social upheaval. No one can foresee just what changes will result, but it is possible to speak in generalities. A movement throughout the world toward the left, which has as its ostensible object the improvement in the condition of the average man and his family, is in process. More consideration is going to be given and better provision made for economic welfare, housing, comfort, recreation and, in particular, for the maintenance of health and for safeguarding against helplessness during the periods of joblessness, illness and old age.

The power of the individual to acquire great wealth is going to be diminished, and institutions such as our private hospitals, endowed medical schools, and universities dependent on private philanthropy will have to look for support to other sources, very probably to the state. There is undoubtedly going to be increased power vested in the state; in other words, in spite of every desire to maintain individualism and power of initiative, more centralized control is going to be forced upon us, for the reason that such is the simple, direct way for the people to get these things which they so fervently desire.

Medical care is so insinuated into the structure of society that inevitably it will be caught in the general upheaval and will share in the changes in general No one can foresee just what the changes in medical care will be, but it is safe to say that, whether we like it or not, they will be considerable, that they will be initiated and dictated largely by the lay public, that the preventive aspects of medicine will have a much more important place than at the present time, and that medical care will be extensively reorganized and increasingly regulated and controlled by centralized authority.

First Things First

Existing plans for socialized medicine contemplate government-sponsored medical care for every minor ache and pain. A criticism of all-inclusive compulsory health insurance is well stated by a medical authority writing in the *Saturday Evening Post:*

"Insurance is essentially for calamities; in every field, it is provision for the small losses that is difficult. Yet it is the cost of serious illness that worries the patients. It is the usual experience of physicians that anyone with a regular job takes the cost of brief sicknesses in his stride. Medical costs of a hospitalized patient should be easy to insure; the costs of certain infirmities requiring long treatment at home could be spread through insurance payments. If we want protection from serious disaster, why impair protection by throwing in trivialities?"

Here is another reason why it will pay to go slow in adopting all-out socialized medicine for the sake of securing benefits that in the end may prove illusory or not even wanted. A mistake would be tragically costly.

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EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the One Hundred Ninety-sixth (196th) Meeting of the Executive Committee of the California Medical Association

The meeting was called to order at 11:00 A.M., on Friday, November 16, 1945, in the Association Headquarters offices in San Francisco.

1. **Roll Call:**

Members Present: John W. Cline, Chairman; Philip K. Gilman, E. Vincent Askey, and George H. Kress, Secretary.

Member Absent: Sam J. McClendon.

2. **Referee Appointed for Solano County Medical Society Hearing:**

The Solano County Medical Society having notified the C.M.A. that it was presenting charges against one of its members, for hearing on December 17, 1945, at 8:15 P.M., in Vallejo, request was made that the C.M.A. appoint a Referee, as per C.M.A. by-law provision, under Chapter II, Section 3, subsection (6). The Executive Committee voted that H. Gordon MacLean of Oakland, act as Referee. (Note. No hearing held. Member resigned prior to hearing.)

3. **Retired Membership:**

On motion made and seconded, Retired Membership was granted the following members, whose applications had been received in accredited form from their county societies:

John P. Nuttall, Los Angeles County,
J. Morris Slemons, Los Angeles County,
Louis George Visscher, Los Angeles County.

4. **1946 Annual Dues:**

A letter of November 9, 1945, from the "Association of Physician and Dentist Health Supervisors of Los Angeles City Schools," relative to dues, was considered. It was suggested that President Gilman reply, calling attention to the provision in the C.M.A. Constitution and By-laws regarding Associate Membership. (C.M.A. Constitution Article IV, Section 1(b). Applications for Associate Membership to be submitted to the C.M.A. Council through respective component county units.

5. **Adjournment:**

There being no further business, the meeting adjourned.

John W. Cline, M.D., *Chairman.*
George H. Kress, M.D., *Secretary.*

75TH ANNUAL SESSION

California Medical Association

AT LOS ANGELES

Tuesday, May 7 - Friday, May 10, 1946

Make note of these dates on your Calendar.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (13)

Sacramento County (2)

Akamatsu, George F., *Sacramento*
Muramoto, Jiro, *Sacramento*

San Francisco County (9)

Bab, Werner, *San Francisco*
Burton, James William, *San Francisco*
Butler, Patrick George, *San Francisco*
Dufficy, Rafael Gabriel, Jr., *San Francisco*
Franklin, Earl Alexander, *San Francisco*
Lippman, Caro W., *San Francisco*
Merritt, John F., *San Francisco*
Minassian, Edward William, *San Francisco*
Schulte, John Walter, *San Francisco*

Santa Cruz County (1)

Raffety, John Orie, *Santa Cruz*

Ventura County (1)

Mangan, Hilary R., *Ventura*

Members Resigned (1)

McNaught, James B., *San Francisco County*

In Memoriam

Black, Benjamin Warren. Died at Berkeley, December 1, 1945, age 58. Graduate of the Medico-Chirurgical College of Philadelphia, Pennsylvania, 1916. Licensed in California in 1928. Doctor Black was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Johnson, Joseph Warren. Died at Pasadena, November 12, 1945, age 35. Graduate of the University of Arkansas School of Medicine, Little Rock, 1938. Licensed in California in 1940. Doctor Johnson was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Mack, Alonzo E. Died at Glendale, November 20, 1945, age 76. Graduate of Creighton University School of Medicine, Omaha, Nebraska, 1896. Licensed in California in 1915. Doctor Mack was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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McQuade, John. Died at San Francisco, November 17, 1945, age 68. Graduate of the College of Physicians and Surgeons of San Francisco, 1918. Licensed in California in 1918. Doctor McQuade was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Shuck, Carl Henry. Died at Fresno, November 11, 1945, age 46. Graduate of Northwestern University Medical School, Chicago, Illinois, 1928. Licensed in California in 1928. Doctor Shuck was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Weston, Frederick William. Died at Tustin, December 1, 1945, age 61. Graduate of the University of Toronto Faculty of Medicine, Ontario, 1913. Licensed in California in 1929. Doctor Weston was a member of the Orange County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Wilbor, Leon Mitchell. Died at Cathedral City, December 5, 1945, age 57. Graduate of the University of Buffalo School of Medicine, New York, 1911. Licensed in California in 1929. Doctor Wilbor was a member of the Riverside County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Wissner, Leonard Otto. (Major, Army of the United States.) Died somewhere in India, November 17, 1945. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1931. Licensed in California in 1932. Doctor Wissner was a member of the Stanislaus County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARY

Benjamin Warren Black, M.D.

1887—1945

We are a group who can speak of death quietly, honestly and without fear, but we cannot speak of the death of Benjamin Warren Black, M.D. without a feeling of irreparable loss.

Dr. Black was born in Fillmore, Utah, May 21, 1887. He received the Degree of Doctor of Medicine from the University of Pennsylvania in 1916, completed his internship, and then promptly entered the United States Army. At the termination of World War I he devoted four years to the United States Public Health Service and then accepted an appointment as executive officer in the U. S. Veterans Bureau. In the course of four busy years, he rose to the position of Medical Director of that organization. In 1928 he accepted the post of Medical Director of Alameda County, a position which he filled ably and well until his death on December 1, 1945.

Dr. Black was a born administrator, a gifted leader, a fluent speaker and facile writer. He administered the affairs of an important medical organization and developed an "Alameda County Plan" which has gained national recognition and esteem. His devotion to the cause of the sick and the poor placed him high in the ranks of communal service. His gifts to his associates and his audiences were given freely and without condescension.

Dr. Black was a member of the Alameda County Medical Association, the California State Medical Association, the American Medical Association, the American Association for Advancement of Science, the Association of Military Surgeons, the American College of Physicians and the American Psychiatric Association. He was a charter member and Past Vice-President of the American College of Hospital Administrators, and a trustee and Past President of the American Hospital Association.

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† For roster of officers of component county medical societies, see page 4 in front advertising section.

His community interests were expressed by his activities in various Masonic bodies, including Scottish Rite and Shrine, Kiwanis International, the Oakland Forum, the Community Chest and the War Manpower Commission.

Dr. Black's final illness found him cheerful and creative to the end. He continued to plan for better treatment of the patients and improvement of the institutions entrusted to his care. May the memory of his philanthropy and the fulfillment of his plans be a continued inspiration to us all.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

15 000 Physicians, 5,000 Dentists Made Eligible For Discharge

In line with its policy of returning doctors and dentists to civilian life as rapidly as the Army's medical needs decline, the War Department has made an additional group of 15,000 physicians and 5,000 dentists eligible for discharge.

Since V-E Day, more than 15,000 physicians have been released from the Army. Under the original schedule, 13,000 were to have been returned to private practice by January 1. The 15,000 already released represent nearly one-third of the total number in the Army at the time of the German surrender. With the additional group made eligible by this recent announcement, two-thirds of the physicians in the Army as of V-E Day will be eligible to resume civilian practice.

To effect the additional discharges, the critical score for physicians and dentists has been reduced from 80 to 70, effective on December 15. The score of 70 for medical personnel is 3 points below the December 1 score for officers in other branches of the Army, and is designed to insure the speediest possible release of men needed in their home communities to provide medical care to the civilian population.

The time factor for physicians and dentists has also been cut. Instead of service prior to Pearl Harbor, medical personnel will now be eligible for release if they have had 42 months of honorable service. This compares with a requirement of four years and three months service for officers outside the Medical Department. In addition, any physician or dentist who is 48 years of age to his nearest birthday is eligible to return to civilian life.

The new standards will apply to all Medical Corps officers except for those in certain scarce categories. For plastic surgeons; eye, and nose specialists; orthopedic surgeons and internal medicine specialists, the discharge requirement will be 80 points or continuous service since Pearl Harbor. A requirement of 70 points or 45 months service has been established for gastroenterologists; cardiologists, urologists, dermatologists, anesthetists, psychiatrists, general surgeons, physical therapy officers, radiologists and pathologists.

The number of doctors in these categories is relatively small but they are essential to the effective care of the 115,000 sick and wounded patients returned from overseas who are now in Army General Hospitals in this country. In the case of all Medical Department officers, provision is made for their retention on duty for a period of not more than 90 days if their services are essential and no replacement is available.

Secretary Patterson has directed that transportation priority be given to medical personnel eligible for return from Europe and the Pacific in order that there may be no delay in their arrival in this country. He has also designated two officers to go to Europe as his personal representatives to make an exhaustive investigation of the release of medical officers there. A similar investigation was recently completed in the Pacific area.

Service Discharges

Army Points Are Cut to 50 and Navy Falls to 36

The Army and Navy, on December 19, announced further reductions in discharge requirements, which will make 837,000 more persons eligible for release. . . .

The age criteria for all army medical and dental officers, except plastic surgeons, will be reduced from 48 to 45 years.

The army said it would continue to discharge personnel in this country who are no longer needed and who do not qualify for overseas duty, even though they lack sufficient points or service.

For dental and veterinary corps officers and all medical officers except certain specialists, the army critical score will be reduced from 70 to 65 points. The factors for release of sanitary corps officers, nurses, physiotherapists, and dietitians remain unchanged.

Veterans' Medical Changes Passed

The Senate passed and sent to the White House, on December 20, a measure reorganizing the medical division of the Veterans' Administration.

It establishes the Office of Chief Medical Examiner with a salary of $12,800 yearly, a deputy at $11,500, eight assistants at $11,000 and a director of nursing service at $8,000.

U. C. Medical Faculty Commended By Navy

A certificate of commendation has been presented to Dean Francis S. Smyth and the faculty of the Medical School of the University of California by the Bureau of Medicine and Surgery of the United States Navy for coöperation in the training of physicians for the Naval Service.

Accompanying the certificate was a letter from Vice-Admiral Ross T. McIntire, Surgeon General of the Navy, in which he congratulates the members of the faculty for their outstanding contribution to the war effort and to medical education.

"It is realized," the letter continues, "the extreme difficulties and obstacles that had to be overcome in accelerating instruction and changing methods in teaching with a faculty depleted by demands of the Services. I feel that medical schools have given a most distinguished service which has had considerable effect on the war effort"

Nebraska Representative Miller Praises Work of Medical Services

The following statement, given by the Honorable A. L. Miller of Nebraska [Congressman Arthur Lewis Miller received his M. D. degree in 1918. Is an ex-president of the Nebraska State Medical Association], in the House of Representatives, is reprinted from the November 23, 1945 Congressional Record:

"Mr. Speaker, the record of the medical men and the medical service in this war is outstanding. It has never been equalled by any Army in any war. There were over 570,000 wounded in World War II, of whom 360,000 were returned to some type of duty. There were some 25,000 or approximately 4 per cent who died of wounds.

"In World War II, only six men in each 10,000 died of disease each year. This is a lower death rate in disease than that of civilians in the same age group here in the

United States; yet these men lived in every part of the world under adverse physical and sanitary conditions. In World War I, 165 in each 10,000 died each year of disease, and these men were serving only in the United States and in Europe; the death rate in the Union Army in the Civil War was 712 per 10,000.

"The death rate from pneumonia has been reduced from 24 per cent in World War I to six-tenths per cent in this war. The death rate for meningitis has been reduced to 4 per cent in this war as compared to 34 per cent in World War I.

"I am sure, Mr. Speaker, that the Congress and the country can look with considerable pride upon this fine record of the medical srevice. There is no record in civil life or elsewhere to compare with this, and certainly a good job has been done in preventative medicine, as well as in the treatment of disease."

Malaria Relapse Rate Declining

The hospital admission peak for malaria relapses in the United States was reached in February, 1945, with a total of approximately 6,000 cases, and has been steadily declining since that time, according to a recent announcement by the Army Medical Department.

During 1943, when men began to return from tropical theaters of operations in increasing numbers, the total number of hospital admissions for malaria relapse reached 5,275. By 1944 it had jumped to almost five times that number—28,150, and in the first six months of this year the total was 30,420.

It is believed, however, that the return of troops from malaria-ridden areas will not appreciably affect the downward trend of admissions, for a large proportion of original personnel already has been replaced and returned. Units and replacements sent to these Pacific-Asiatic regions after the middle of 1943 are not expected to show as high rates of infection as those of earlier groups.

Hospital Crisis

Army and Navy Recklessly Abandoning Costly Equipment Urgently Needed By Veterans

In view of the current shortage of hospital accommodations, it would be a good thing if the armed services and the Veterans' Administration could get together in regard to hospital requirements for discharged service men and women.

Right and left, the Army and Navy are closing excellently equipped and efficient wartime hospitals because those in uniform no longer are being wounded or stricken with disease in considerable numbers while in action.

Note the recent closing of Hammond General Hospital in Modesto, which, under Colonel L. R. Proust, won standing as one of the finest medical institutions in the Ninth Service Command by saving the lives and healing the bodies of more than 15,000 veterans during its three years of existence.

Yet at the same time, the Veterans' Administration is encountering great difficulty in obtaining hospitalization for discharged veterans throughout the nation, and the situation is particularly acute in the bay area.

To provide for those requiring further care following discharge, the Veterans' Administration recently requisitioned some 20,000 beds in already overcrowded private hospitals, and an equal number in Army and Navy hospitals still operating.

This seems to be another instance of one governmental agency abandoning and wasting equipment and facilities urgently needed by another.

Let it be granted that the staffs of service hospitals should be demobilized. They could be demobilized and retained in their positions at civilian rates of pay as employees of the Veterans' Administration to permit the continued operation of their hospitals until such time as the VA could expand its facilities to meet its needs

And many of them would welcome such procedure as an expedient to tide them over the postwar period. The VA is paying prevailing private hospital rates for requisitioned beds anyway.

Such a step would require only a little inter-departmental coöperation and a little cutting of red tape. And it would provide welcome relief in the hospital crisis for veterans and non-veterans alike.—Editorial in San Francisco *Call-Bulletin*, January 3.

President Truman Signs Bill for Veterans' Administration Medical Staff

Washington, Jan. 3.—President Truman tonight signed into law a bill establishing a separate department of medicine and surgery within the Veterans' Administration after resisting heavy pressure from two government agencies to veto it.

General Omar N. Bradley, administrator of veterans' affairs, and Major General Paul R. Hawley, VA surgeon general, have strongly favored the bill as the cornerstone of a strengthened medical and surgical service for veterans.

But opposition to it—for what it doesn't do rather than for what it does—came from two sources:

1. The American Legion, the Disabled American Veterans and the Veterans of Foreign Wars showed open concern because the bill does not specifically call for veterans' preference in granting jobs coming under the bill's provisions. The DAV at first called for a veto so this oversight could be fixed. The other two groups merely called the omission to the attention of the President. After receiving assurances from Bradley that veterans would not be overlooked, the DAV also dropped its objections.

2. The Civil Service and Budget Bureaus have objected to it because it permits Bradley to hire and fire doctors and surgeons without Civil Service approval.

While President Truman could not himself add a veterans preference provision to the bill, he apparently met the veterans group's objections. In a letter to Bradley, he said:

"It is my desire that, in carrying out the provisions of this law, you develop a system of recruitment and placement which will grant priority to qualified veterans and which will also provide against any possibility of discrimination because of race or creed."

The President did not mention the Civil Service objections to the measure.—San Francisco *Chronicle*, January 4.

Medical Veterans Refresher Course—University of California

Intended primarily for Doctors of Medicine recently discharged from active duty with the armed forces is a group of refresher courses which University of California Extension will inaugurate early in 1946, according to Dr. Baldwin M. Woods, Director.

The courses will cover general principles and recent advances in the various divisions of Medicine, related basic sciences, Public Health, Surgery and the surgical specialties. Courses will be offered on the Los Angeles campus two evenings per week, two hours per evening, with lecturers drawn from the faculty of the University of California School of Medicine, from among basic science professors on the Los Angeles campus, and from among leading physicians and surgeons in the Los Angeles area. A substantial number of refresher lecture courses in medical specialties will be provided. Several outstanding authorities from the East and Middle West will participate.

Immediate application for registration is recommended because of the limited enrollment which can be accommodated. Applications will be honored, insofar as space permits, from Doctors of Medicine in practice. Applications, as well as inquiries as to eligibility under State and National Veterans' Educational Bills, should be directed to University of California Extension, Los Angeles 24, California.

Military Clippings.—Some news items of a military nature from the daily press follow:

Selective Service—Awake at Last

Just short of four years since Pearl Harbor, Selective Service now has advised local draft boards to defer registrants who are teaching or studying physical or chemical science or engineering.

It has taken the government a long time to get around to the idea that it is a waste of the social substance needed in modern war to put highly trained men, or embryo scientists, to peeling potatoes or the manual of arms.

Selective Service did take steps early in the case of doctors and medical students. It was possible to penetrate the Army mind and the sense of politicians with the fact that doctors are needed in a war. But, in spite of persistent urging from competent scientific sources, the draft brass hats went right on classifying chemical, physics and engineering students with talented youths who can play violins, draw pictures or produce literature, gifts that have no bearing on war's necessities.

In the present directive to draft boards, no mention of the atom bomb is made. But that evidently is what has brought official awareness of what almost everybody else has known, that science is essential to the military life and that its human material should be kept in production. —Editorial in San Francisco *Chronicle*, December 2.

MacNider Son Release Brings Plea for Medical Students

Washington, Nov. 28.—(UP.)—Discharge of a General's son so that he could return to pre-medical school brought a demand today for the immediate discharge of all medical and pre-medical students. . . .

Kilday pointed out, however, that medical students must take refresher courses after prolonged absence from school and said that in the face of a shortage of physicians, all should be discharged without delay. . . .—San Francisco *Chronicle*, November 29.

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

Because of war conditions no scientific assemblies were held by the American Medical Association in 1945.

However, with improvement of transportation facilities, the House of Delegates of the American Medical Association held a meeting in Chicago on December 3-6, 1945.

In the *J.A.M.A.* of December 15th (page 1105) and December 22nd (page 1178) appear the proceedings of the House of Delegates. Reports of officers and standing committees and bureaus are presented in detail. Under New Business commencing on page 1189 are given the resolutions presented by delegates from the constituent state medical societies.

The California Medical Association had eight delegates in attendance: Dwight L. Wilbur, San Francisco; S. J. McClendon, San Diego; Lowell S. Goin, Los Angeles; Dwight H. Murray, Napa; H. Gordon MacLean, Oakland; E. Vincent Askey, Los Angeles; John W. Cline, San Francisco; and Donald Cass, Los Angeles.

The C.M.A. delegates presented three resolutions, the same being considered in executive session by the A.M.A. House of Delegates. For the information of C.M.A. members, the resolutions introduced and the action thereon by the A.M.A. House in executive session, follow:

Resolution on Activities of Employees of American Medical Association

(Presented on December 3, 1945)

Dr. S. J. McClendon, California, presented the following resolution, which was referred to the Reference Committee on Executive Session:

WHEREAS, At this time many important problems confront the medical profession; and

WHEREAS, The American Medical Association is in need of the most efficient organization possible in the solution of its problems; and

WHEREAS, Employees who participate in activities outside of the Association cannot render their best service to the Association; therefore, be it

Resolved, That all employees of the Association who are not specifically employed on a part time basis shall be required to devote their full time to the activities of the Association for which they are employed and shall not engage in outside activities from which they derive financial income.

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Resolution on Spokesman for American Medicine

Dr. L. S. Goin, California, presented the following resolution, which was referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, The past few years have seen the development of several organizations designed to protect the corporate body of medicine from governmental encroachment, this development being the reply to the obvious demand and need for such protection; and

WHEREAS, The American Medical Association only recently has created a Council on Medical Service and Public Relations, which by reason of red tape and administrative difficulties has scarcely yet begun to serve its real purpose; and

WHEREAS, The delegates from California believe in this Council, approve of its stated objectives and are desirous of so implementing the Council that it may in fact as well as in theory accomplish those things for which it was intended; now therefore be it

Resolved, That this House directs that the Council on Medical Service and Public Relations shall be the sole spokesman for American medicine; that it shall be given whatever funds it may require to carry out the purposes for which it is intended, and that the Council be directed to retain an executive for full time service, with such secretarial assistance as he may require, the House of Delegates stating explicitly that the qualifications of such executive shall be determined only by the Council.

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Resolution on Council on Medical Service and Public Relations

Dr. Dwight Wilbur, California, presented the following resolution, which was referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, The American Medical Association has created a council on public relations, known as the Council on Medical Service and Public Relations, which Council is charged with the responsibility of representing the American Medical Association to the public and governmental agencies of the United States; and

WHEREAS, The presentation of the official point of view of the American Medical Association by other councils, committees and individuals leads but to confusion and to different and divergent views, with the effect of apparent disunity in the profession; and

WHEREAS, At this time the profession is in need of greater unity than ever before in its history; therefore be it

Resolved, That the Council on Medical Service and Public Relations shall be the sole agency for presentation of the attitude of the American Medical Association relative to matters in which the organized profession should or must make representation to the public or to the government.

Executive Session (December 4)

The Sergeant-at-Arms polled the House, and after a short recess the House went into Executive Session.

Dr. Walter F. Donaldson, Chairman, presented the following report:

Three resolutions were referred to the committee, the first being a resolution regarding the activities of employees of the American Medical Association.

1. Resolution on Activities of Employees of American Medical Association: Your reference committee, aided by the comments of those who attended its hearing and by careful subsequent consideration, respectfully submits the following as its reaction to said resolution: Article 2 of the Constitution of the American Medical Association in twenty words sets forth the objects of the Association as being to promote the science and art of medicine and the betterment of public health. Section 1 of chapter VI of the Association's By-Laws states that the Board of Trustees shall appoint a General Manager and an Editor of *The Journal* and such assistants as may be necessary and shall determine their salaries and the terms and conditions of their employment. Therefore there seems to be little doubt that this resolution, if adopted by the 1945 House of Delegates, would, in effect, express a definite criticism of the administration by the current Board of Trustees, whose multiple, year-round activities involve interim supervision and responsibilities for the success or failure of the policies and plans authorized and approved by each succeeding House of Delegates. Never has this Association stood in greater need of harmony between its legislative and administrative bodies than in the coming year 1946. Your Reference Committee on Executive Session is confident that the Board of Trustees is devoted to and capable of developing and maintaining the most efficient organization possible in the solution of the Association's present pressing problems, provided it has the support of the membership. To this end we would call to the attention of the entire membership of the Association that in the interim between meetings of the House of Delegates the Board of Trustees is an ever open and easily approached avenue for criticism or complaint. We also urge each member of the House of Delegates and others present to make it clear to their constituency that Fellows of the Association will always find warm welcome should they care to attend the meetings of the House of Delegates. Your committee heartily recommends this in order that the members throughout the constituent associations may be properly impressed with the democratic structure and processes of the House of Delegates. Your reference committee recommends to the House that this resolution be not approved.

2. Resolutions on Spokesman for American Medicine and Resolution on Council on Medical Service and Public Relations:

Your reference committee has taken the liberty of considering these resolutions jointly, which deal with expansion of the functions and the implication of the already multiple duties and activities of the Council on Medical Service and Public Relations. The present duties of this council are clearly defined in the By-Laws of the Association, which, of course, are at all times subject to amendment. The members of your reference committee have learned through interviews with members of similar councils of constituent state medical associations that it has been a common exeperience that the magnitude of the subjects assigned to each such council, none of which have been in existence more than two years, has tended to create a certain degree of confusion strongly suggestive that more time will be required for crystallization of activities within the limitations of time available to the personnel of such councils. The members of our committee learned at its hearing this morning, from a former and the current chairman of the Council on Medical Service and Public Relations, that the Board of Trustees of the American Medical Association has throughout shown a completely coöperative attitude and has been generous in the provision of funds and of personnel. It learned too from those who presented the resolutions that their basic objective was and is to encourage the Association and to assist in every way possible in bringing about not only effective but timely action by this new and important council.

With these ideas in view, your reference committee unanimously recommends that the resolutions dealing with the future of the Council on Medical Service and Public Relations be not approved.

Respectfully submitted,

WALTER F. DONALDSON, *Chairman.*
EDWARD JELKS.
JAMES R. MCVAY.
WILLIAM R. BROOKSHER.
THOMAS P. MURDOCK.
W. CLARK BAILEY.
ALLEN H. BUNCE.

Dr. Donaldson moved that the first section of the report of the reference committee, disapproving the Resolution on Activities of Employees of the American Medical Association, be adopted, and the motion was seconded by Dr. A. A. Walker, Alabama. After discussion by several, it was moved by Dr. James P. Kerby Utah, duly seconded and carried by a vote of 88 to 48 that the vote on the adoption of this section be by secret ballot.

The Speaker requested the tellers to spread the ballot for a vote on the adoption of the first section of the report of the reference committee. The tellers spread the ballot, the Speaker declared the ballot closed and the Secretary announced that 166 votes had been cast, of which 106 were for the adoption of the first section of the report of the reference committee and 60 were opposed.

The Chairman ruled that the first section of the report of the reference committee, disapproving the Resolution on Activities of Employees of the American Medical Association, had been adopted.

It was moved by Dr. Donaldson that the second section of the report of the reference committee, disapproving two resolutions dealing with the functions of the Council on Medical Service and Public Relations, be adopted. Dr. L .S. Goin, California, desired to enter a motion for the amendment of one of the resolutions, which amendment he read and moved its adoption. The motion was seconded by Dr. John W. Cline, California. After discussion, the Speaker ruled that the House hear Dr. Donaldson's report before considering any amendment.

Dr. Donaldson completed the reading of the second section of his report and moved its adoption. Dr. L. S. Goin moved that this be rereferred to the conference committee, and the motion was seconded and carried after discussion by several and this section of the report of the reference committee was rereferred to it.

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Executive Session (December 5)

The House went into Executive Session on motion of Dr. Arthur J. Bedell, Section on Ophthalmology, seconded and carried.

The Sergeant-at-Arms cleared the House of all but those entitled to remain, and the Speaker declared the House in Executive Session.

Report of Reference Committee on Executive Session

Dr. Walter F. Donaldson, Chairman, presented the following report, which on motion of Dr. Donaldson, seconded and carried after discussion, was adopted:

Resolution on Council on Medical Service and Public

Relations and Amendment: Your reference committee has reconsidered the original resolution and has considered the amendment to the original motion submitted to the House of Delegates.

The duties of the Council on Medical Service and Public Relations as outlined in the By-Laws have been reviewed. Your reference committee reviewed the manifold duties of this council as outlined on pages 165 to 180 in the Handbook.

Your reference committee feels that this council is already overwhelmed with work assigned to it that more properly belongs to other committees. Furthermore it believes that this council has done excellent work to date and is to be commended. It feels that the Board of Trustees should clarify the duties of this council. There is evidence that the Council will be assisted materially when the Bureau of Medical Economics is revived.

Your reference committee has been informed that provision has been made by the Board of Trustees to engage public relations counsel.

For the foregoing reasons your reference committee believes that it is unwise to add to the duties of the Council at this time. It further believes that, in the interest of harmony and at such a critical time in American medicine, this is a most inopportune time to consider such resolutions and amendments.

Your reference committee has complete confidence in the Board of Trustees to carry this matter to a successful conclusoin. It feels therefore that, for the reasons outlined in the original report of the committee and those outlined here, the resolution and amendments should be disapproved.

Respectfully submitted,

WALTER F. DONALDSON, *Chairman.*

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Proposed Amendment to the A.M.A. By-Laws, Chapter XII, Section 2

Dr. L. S. Goin, California, submitted the following proposed amendment to the By-Laws, chapter XII, section 2, which was referred to the Reference Committee on Amendments to the Constitution and By-Laws:

Resolved, That section 2 of chapter XII of the By-Laws be amended by striking the words "and subscribe to THE JOURNAL," and further amend section 2, chapter XII, by inserting after the words "is disapproved by the Judicial Council (line 8, p. 30) a new sentence to read "Fellows shall receive *The Journal of the American Medical Association.*" (Note. Resolution lies over for one year.)

* * *

Affiliate Fellowship approved by the Council on Scientific Assembly was granted to the following California physicians: J. David Beatty, Los Angeles; James B. Bullitt, San Jose; H. B. Graham, San Francisco; Edward C. Sewell, Stanford University; J. Morris Slemons, Los Angles; L. G. Vischer, Los Angeles; and N. E. Williamson, Los Altos.

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In the election of officers, Doctor William R. Molony, Sr., of Los Angeles, was elected Vice-President of the American Medical Association. Doctor Dwight H. Murray, Napa, was elected a member of the Board of Trustees of the American Medical Association, to fill the unexpired term ending in 1947, of Doctor Edward M. Pallette, deceased.

* * *

The action taken three years ago to hold the 1946 annual session of the American Medical Association in San Francisco was approved.

WESTERN UNION TELEGRAM

Chicago, December 28, 1945.

Conference of State Medical Association Secretaries and Editors will be held at the American Medical Association's offices in Chicago on Friday, February eight and Saturday, February nine.

Officers and members of official bodies of State Associations and County Societies will be welcome.

First session at ten A.M. Friday, February eight.

Conference will close after Saturday morning program completed.

Signed: OLIN WEST, *Secretary,*
American Medical Association.

Los Angeles Hotels For 75th Annual Session, May 7-10, 1946

The official headquarters of the next annual session of the California Medical Association to be held at Los Angeles, Tuesday, May 7 through Friday noon, May 10, 1946, will be the *Hotel Biltmore*, 515 South Olive Street (Olive, between Fifth and Sixth Streets), Los Angeles. Because of postwar conditions and prospective attendance, the facilities of other hotels must also be used.

All requests for reservations must be sent to the hotels direct. In writing, it is well to state the number in the party, date of arrival, date of departure, nature of accommodations desired (single room, double room, double bed, twin beds, bath).

LOS ANGELES HOTELS: WITH TELEPHONE NUMBERS

A list of some hotels in Los Angeles within easy distance of the Hotel Biltmore.

Hotels	*Telephones*
Alexandria Hotel, 210 W. Fifth St.	(MAdison 2741)
Ambassador Hotel, 3400 Wilshire Blvd.	(DRexel 7011)
BILTMORE HOTEL, 515 S. Olive	(MIchigan 1011)
Carlton Hotel, 519 S. Figueroa St.	(MIchigan 6571)
Chapman Park Hotel, 516 S. Alexandria Ave.	(FItzroy 1181)
Clark Hotel, 426 S. Hill St.	(MIchigan 4121)
Gates Hotel, 831 W. Sixth St.	(TRinity 3931)
Hayward Hotel, 206 W. Sixth St.	(MIchigan 5151)
Mayfair Hotel, 1256 W. Seventh St.	(FItzroy 4161)
San Carlos Hotel, 507 W. Fifth St.	(MUtual 2291)
Savoy Hotel, 601 W. Sixth St.	(MAdison 1411)
Stillwell Hotel, 838 S. Grand Ave.	(TRinity 1151)
Town House, 639 S. Commonwealth Ave.	(EXposition 1234)
William Penn Hotel, 2208 W. Eighth St.	(EXposition 3181)

Los Angeles County Medical Association Establishes an Indoctrination Course for Applicants to County Society Membership

The following discussion of an Indoctrination Plan appeared in the *Bulletin* of the Los Angeles County Medical Association of October 4.

The Council of the Los Angeles County Medical Association instructed a committee to proceed with its implementation. Secretary E. T. Remmen of the Los Angeles County Medical Association made the following editorial comments concerning the plan:

"That every applicant for membership in a component county medical association should be required to attend a course of lectures designed to indoctrinate him thoroughly in certain aspects of the successful practice of medicine, was the substance of a resolution recently adopted by the Council of the California Medical Association. The plan was discussed by the Council of the Los Angeles County Medical Association at its last meeting. If the program is accepted, every physician who seeks membership will be required to attend and to pass an examination on the subject matter of a series of lectures by qualified instructors in professional ethics, malpractice prophylaxis, laws governing medical practice and narcotics, the state poison act, public health ordinances, and laws governing birth, death, and other certificates. The history of our county medical association—its aims, accomplishments and struggles—should be taught to every new member. Each applicant should become familiar with the work of the Physicians' Aid Association and the Medical Milk Commission. He would also derive benefit from information concerning the county hospital, the health departments, the coroner's office, workmens' compensation laws and proper conduct as an expert witness.

"At first thought, it may appear unreasonable to require persons who possess the educational qualifications for membership in this association to attend lectures on these subjects. For some it will indeed be superfluous. Most of our applicants, however, are either recent graduates with little or no experience in private practice or older practitioners who have left former locations. Among the latter are many experienced and capable physicians with excellent records, but with them come others who have migrated because of failure elsewhere. This group needs all the help which can be given.

"The Los Angeles County Medical Association has been a powerful influence in improving the quality of practice in this great county. Its influence will become much greater in the future, but that influence will be great in direct proportion to the quality of its members. It must scrutinize future applicants for membership with the most meticulous care. If doubt exists as to the applicant's past record or as to his character or professional ability, his admission should be deferred until all doubt is removed or until he has practiced long enough in this locality to permit an accurate appraisal of his ability and character. In addition, the most rigid ethical standards should be applied to our own members. There should be no hesitancy on the part of the council to discipline severely the few members whose business tactics are nothing more than extortion, whose manners and conduct are ungentlemanly or who conduct themselves or their practice on a level below that which is suited to a decent community.

"Such members are a very small percentage of the whole, but their names recur again and again in complaints received at Association headquarters. Usually the offenses are not of a nature which permits expulsion under present rules, but they are nevertheless culpable and they discredit every member of the society. With the Council at large and representative as it now is, and with the right of appeal protected, it would seem that the time is ripe to adopt a strict and specific code of ethics with ample penalties which would rid us of the occasional heartless grafter and the still more infrequent uncouth boor who bring more disfavor upon the profession than a hundred honorable men can overcome. These individuals are well aware of the fact that membership in the Association is practically a necessity if hospital privileges are to be retained, and they are careful to keep within the letter of the by-laws as they are written at present.

"The Code of Ethics of the American Medical Association is a statement of principles, rather than a penal code. It is left to each county society to establish its own code. From time to time our own society has adopted enactments governing the conduct of members in specific circumstances. These should be compiled and codified. Obsolete provisions should be repealed and a comprehensive and modern code of professional conduct adopted. This could and probably would be enforced.

"The possession of a license from the Board of Medical Examiners to practice medicine is one thing. It is quite another to be a member of a county medical association. The state license is granted in obedience to laws made by laymen. Medical society membership is granted only to those who meet the approval of their own profession. If undesirables gain admission to the Los Angeles County Medical Association it is because applicants for membership are so numerous that the Committee on Admissions cannot possibly have personal knowledge of them all. If the indoctrination plan is adopted, each applicant and his attitude will become well known to his instructors before he is accepted for membership.

"The state law provides that a license must be issued to those who comply with certain requirements as to education and moral character. Licenses are often issued to recent graduates who have yet to practice medicine without being supervised by faculty members and hospital staffs. A certain percentage of these young physicians lack the character and moral stamina to play the game of life according to the rules. They may use improper methods of getting business, treat their colleagues unfairly, advertise improperly, or form associations with shady individuals and groups. Their need for money may cause them to perform abortions or to issue false certificates of illness. Others succumbs to alcohol and narcotics. Still others use business methods which are dishonest, or at least offensive, to persons accustomed to high standards.

"Membership in the County Medical Association is becoming more and more necessary to physicians. As more hospitals become standardized, it is very difficult for a non-member to find accommodations for his patients. Insurance companies and governmental agencies are seldom interested in a physician who is not a member in good standing of the regular medical organization. The medical profession itself is therefore developing effective police power over its own members above and beyond that possessed by the State Board of Medical Examiners. The time is not far distant when physicians who cannot behave as gentlemen (or ladies) in the highest sense will find themselves engaged in some occupation where fundamental decency is less important.—E.T.R."

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

California Assemblymen's Hospital Inquiry Held Detrimental

Welfare Council Board Calls Methods Used and Sensational Headlines Unfortunate

The method and nature of the California Assembly Interim Committee's recent hearings on the Los Angeles County General Hospital "has had a detrimental social effect," the executive board of the Welfare Council of Metropolitan Los Angeles declared in a statement on December 13.

"This can be remedied only by a competent, impartial and thorough study of the institution, with proper methods for revealing the essential facts of such an undertaking to the citizens of this community," the statement, signed by Mrs. Sumner Spaulding, president of the welfare council, said.

Skilled Personnel Needed

The statement asserted that in the first place "it is our conviction that an adequate appraisal of health institutions requires competent and skilled personnel."

"It *is* unfortunate that the interim committee undertook to evaluate medical and related matters about which it could not come to sound judgments without technical assistance."

The executive board, which received a report from its health division, also criticized the emphasis which the hearings placed "upon the so-called 'dissatisfied patient.'" This, the statement continued, "completely overlooked the very real crisis which all institutions have faced during this war period as regards manpower and related shortages."

"In our view," the board added, "the management of this institution has done an admirable job in the face of these difficulties, while the record shows conclusively that these public officials have continuously called public attention to critical shortages and handicaps under which these institutions operate."

The board also deplored publicity given in some newspapers "to the small but articulate group of dissatisfied citizens."

"Charge Without Basis"

It added that sensational headlines in a newspaper constituted not only "a serious charge with no basis in fact, but a psychological blow of damaging proportion to the sick of the community within and outside the hospital.

"The evidence shows that this has had a negative effect on the attitude of the citizens generally in respect to one of its public institutions and has served to undermine much needed confidence and well-deserved faith in this particular institution."

New $120,000 Nursery Clinic

On December 10 Children's Home Society of California, at 3100 W. Adams Blvd., Los Angeles, opened its new clinic.

The newest facility of the nonprofit State-wide adoption agency will house infants requiring special care immediately following birth and will also maintain a clinic for children of all ages, as well as quarters for staff training and similar activities. It is being financed by individual private subscriptions, a major proportion of which already have been contributed.

Dante Hospital in San Francisco

Purchase of the Dante Hospital of San Francisco by the Roman Catholic Church for operation as a general hospital, was announced on December 6.

Spokesmen for Archbishop Mitty said operation of the hospital will begin when the Army gives up the establishment in about 18 months. The church, it was said, was the actual purchaser when the property was acquired last week for $750,000 by a group of doctors headed by Dr. Edmund J. Morrissey.

Jewish Charities Open Drive For Proposed Health Center in San Francisco

A campaign is under way to raise funds for the proposed new Maimonides Health Center, planned by the San Francisco Federation of Jewish Charities to care for the chronic sick.

A site has been selected on Sutter Street, near Mt. Zion Hospital, to facilitate use of that hospital and its medical staff.

The health center project has been indorsed by the Social Planning Committee of the Community Chest, Dr. Wilton L. Halverson, State director of public health; Dr. J. C. Geiger, city health director and Dr. Harold Brunn, Mt. Zion hospital chief of staff.

The center is designed to meet an increase in chronic illness. It will provide unlimited medical therapy to all on a pay, part pay or free basis, it was announced.

New $1,000,000 Unit of Queen of Angels Hospital

A new $1,000,000 maternity unit was dedicated on December 10, at Queen of Angels Hospital, by Archbishop John J. Cantwell in ceremonies at Los Angeles, attended by church and civic leaders and several hundred friends of the institution.

Addition of the 177-bed wing makes Queen of Angels the largest private hospital west of the Mississippi, Dr. Lowell S. Goin, chairman of the medical advisory board, who presided, declared.

Msgr. Thomas J. O'Dwyer, director of Catholic charities for the archdiocese, thanked officials of the U. S. Public Health Service for approving the construction program to help alleviate the critical hospital shortage here, and praised the Franciscan Sisters, who, he said, "reflect here the charity of Christ."

The sisters and hospital staff were also lauded by Joseph Scott, attorney and prominent Catholic layman, who asserted, "I am here as example No. 1 of how they can keep a man with a vile temper and bad habits alive to the age of 78."

U. S. Senate Approves Hospital Bill

Legislation providing grants to states for construction of hospitals, as President Truman proposed in his message this week to Congress, has already been reported favorably from the Senate Committee on Education and Labor.

It would, if passed, provide for allotment of $1,900,000 to California each year for five years, for hospital construction, provided state, local and private funds to the extent of $3,980,000 were provided for matching.

The bill was reported October 30.

"Lack of health facilities—properly placed and adequately equipped—represents one of the weakest spots in our national health structure," the report says. "Preventive medicine, although still inadequate, at least rests upon the firm foundation of local, state and Federal governmental support of public health services. Medical care, predominantly in the hands of the private physician, is normally available and of better quality in communities where hospital facilities are adequate, and sometimes unavailable or of inferior quality where hospitals are lacking."

The Committee recommended a construction program under the direction of the U. S. Public Health Service. Its bill authorizes expenditure of five million dollars for allotment to the states to survey their hospital needs and plan to meet them. It authorizes $75,000,000 for allotment to the states for construction, every year from 1947 through 1951.

The money would be allotted on a formula based on the per capita income of each state, population and ratios with the national figures.

California, having the third highest per capita income in the country (Connecticut's and Nevada's are larger) would get a relatively small share of the $75,000,000. . . . —San Francisco *News*, November 24.

Problems Confronting American Hospitals

Arthur C. Bachmeyer, M.D., Director, University of Chicago Clinics, Director of Study, Commission on Hospital Care, in a communication to the House of Delegates of the American Hospital Association, outlines as follows:

Confronted with immediate problems within their own institutions, hospital administrators seldom have opportunity to plan for the future development of their own institutions, much less for the health facilities of their communities and of the country. To meet the increasing demands for hospital service, it is necessary to understand the trends influencing hospital functions.

Construction or extension of hospital is usually preceded by planning limited to a study of the extent, capacity for service and future prospects of the individual institution. Many health leaders, including hospital administrators who initiated the Commission on Hospital Care to study hospital facilities in the United States, are working earnestly on plans to extend and better coördinate the nation's hospital facilities. Some broad relationship problems confronting American hospitals today have been crystallized by the preliminary experience of the Commission on Hospital Care.

The discrepancies in services offered by hospitals in smaller communities as compared with those in metropolitan areas may be lessened to mutual benefit through the development of organic relationships and coördination between and among these institutions.

To perform fuller services in general hospitals, the small and also many of the large, and to provide adequate care to meet the public need through an effective and economic operation, the following services must be considered:

Special facilities for the care of acute communicable diseases, early stages of nervous and mental diseases, and chronic diseases.

Routine x-ray of patients and personnel for traces of pulmonary tuberculosis; rehabilitation programs and other provisions for increased service to convalescents; organized personnel training programs, with larger hospitals possibly training employees for small institutions.

Further development of the hospital as a health and medical center.

More ready availability of hospital facilities in rural areas, solution undetermined.

Extended public health activities and coöperation.

Pursual of better business methods and promotion of Blue Cross, with the correction to a cost basis of governmental payments for the care of indigents.

Experiences during the past war years have placed hospitals in an enviable position financially, in medically advances, and in public confidence. Because of the recent scarcity of building materials now released, they find themselves on the threshold of a great expansion program. An integration of service will lead to a strong hospital system and benefit individual institutions and public alike. Voluntary organization for the systematic distribution of hospital service to solve a public problem and provide a public service appears to be within reach of hospitals today.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

California Above National Average But Below Standards in Public Health Nurse Employment

The United States now has a total of 20,818 public health nurses, or one public health nurse for every 8,300 people, according to statistics supplied by the United States Public Health Service.

The distribution of public health nurses according to population ranges from one public health nurse to every 2,900 people in an Eastern State to one for 18,300 people in a Southwestern State. There are 909 counties without a public health nurse.

The last count made in California was on January 1, 1945. On that date, there were 1,440 public health nurses employed, or one for every 6,141 persons based on a population estimate of 8,842,700.

The minimum standard advocated by public health authorities is one public health nurse to every 2,000 to 5,000 population.

In California 14 counties had one nurse to every 5,000, or less, population. They are: Alpine, Del Norte, Inyo, Kings, Marin, Mariposa, Mono, San Diego, San Luis Obispo, Santa Barbara, Solano, Sutter, Ventura and Yuba.

The population served by one public health nurse was 10,000 or more in eight counties; Humboldt, Mendocino, Napa, Placer, San Benito, San Joaquin, Siskiyou and Stanislaus.

The people in six counties did not have the service of a public health nurse on January 1st. They are: Calaveras, Colusa, Glenn, Plumas, Sierra and Trinity.

Although the total number of public health nurses employed in the nation is reported to have remained static during the war, the number in California increased by 127 from January 1, 1944, to January 1, 1945

On Relationship Between Medical and Nursing Professions

A recent questionnaire on the relationship between the medical and nursing professions includes the queries listed below. Members of the two professions, who are interested, may wish to make mental answers to the questions that follow:

QUESTIONNAIRE

1. What effect, if any, has the war had on:
    (A) Medical-nursing relations in this country?
    (B) Nursing skills and methods?
2. What are the maladjustments between the nursing profession and the medical profession?
    (A) Real maladjustments?
    (B) Mental maladjustments? (that is, in people's minds due to apathy, ignorance, prejudice, etc.)
3. What do you recommend to improve nursing-medicine relations as between:
    (A) Medical societies and nursing organizations?
    (B) Educational bodies of both groups?
    (C) Hospital administrations and nurses?
    (D) Physicians and
        1. Hospital nurses?
        2. Public Health Nurses, including industrial?
        3. Private Duty Nurses?
        4. Nurse educators?
    (E) Nurses and their patients?
    (F) Physicians and nurse placement services, i.e., registries and the like?
4. What do you think the future trend of thinking in the medical professoin will be as regards:
    (A) The use of practical nurses?
    (B) The more extensive use of nurses through the provision of:
        1. The Social Security Act and other federal legislation?
        2. Voluntary prepayment plans for medical and hospital care?
5. What steps do you think should be taken to improve the relationships between the medical and nursing profession?

Shortage of Nurses

Hospitals Reported Forced to Reject Patients—It's a Statewide Problem

"Two hundred and fifty registered nurses are needed in San Francisco hospitals immediately. Critically ill patients are now being turned away from hospitals because there aren't enough nurses to provide them with minimum care."

This condition was announced on December 1, by the San Francisco Hospital Conference.

At a meeting of officials of the conference it was reported a canvass of its membership, comprising the 18 principal general hospitals of the city, revealed more than 100 beds are not being utilized in those hospitals due to the lack of nurses. Authorities stated the shortage has reached the danger point.

The County Nurses Association reported that of approximately 1,000 San Francisco nurses who entered the armed services, more than one-half came from hospitals. To date, only nine have returned to hospital service.

According to Charles A. Wardell, President of the Association of California Hospitals and a member of the San Francisco Conference, the only way the present emergency can be met is for registered nurses who are not employed in hospitals to report to their Association immediately for such duty. He asked that all Red Cross Nurses' Aides assume voluntary hospital work.

Mr. Wardell said the nurses' shortage exists throughout the State. He revealed that more than 40 per cent of the nurses working in 300 Association of California Hospitals were called to duty with the armed services. A majority of student nurses in the State were enrolled into the nursing division of the medical corps upon graduation, he said.

An act of the last State Legislature enabled hospitals to employ graduate nurses from out of State, Wardell stated, but their term of service expires immediately after Congress declares the official termination of hostilities.

"Every hospital in this State needs nurses," Mr. Wardell declared. "Wards and rooms are being closed and this condition will continue until those nurses who are available and are unemployed, or who are employed in other positions, come forth to assist in meeting a situation which is more acute than it has been since Pearl Harbor."—San Francisco *Chronicle*, Decmeber 1.

"Back to School" Is Choice of Nurse Veterans

Education—advanced or supplementary—is challenging graduate professional nurses today to an unprecedented degree.

Nurse veterans can receive educational benefits under the G.I. Bill for a year's work in approved institutions, or longer in specified cases; if disabled, they may, under Public Law 16, receive up to a maximum of four years' education.

Bolton Act funds for postgraduate study over a period ending June 30, 1946, are still aiding other nurses, admitted before October 15.

Alumnae and other scholarship funds, some of them left intact during the war, are now being drawn upon by others.

Preparation for the responsibilities of postwar nursing is the goal of many, in military service and out. But choice of sound programs of study is not always easy.

To assist nurses and their counselors in the choice, a summary of criteria is being developed by the National League of Nursing Education. Descriptive lists of courses and programs, though not accredited by the League, are available for (1) advanced programs leading to a degree in universities and colleges; (2) clinical nursing courses available for graduate professional nurses. (15c for the first, 25c for the second, from the NLNE, 1790 Broadway, New York 19, N. Y.)

War's End Brings Changes to All Fields of Nursing

Return to civilian life of many Army nurses—25,000 by January 1; 15,000 more by June 1.

Return of many Navy nurses—2,000 by February, 7,000 by September.

Ending of Procurement and Assignment Service by January 1, and recommendation that voluntary state groups take over committees' records and most essential activities.

No immediate change in hospital and other civilian nurse shortages.

Continuing campaign to "Help Hospitals" maintain nursing services.

Urgent need of Veterans Administration hospitals for 2,000 more nurses.

End of recruiting for Cadet Nurse Corps of U. S. Public Health Service but continuation of Bolton Act funds for all students accepted before August 21 and entered by October 15.

Need for new philosophy and procedure for recruiting student nurses.

Continuation of senior cadet program, but with maximum assignments to Federal Government nursing services limited in line with decreasing military and naval needs.

Continuation of Bolton Act postgraduate scholarshpis no later than June 30, 1946, for nurses enrolled by October 15.

Impetus to advanced study by former Army and Navy nurses, under provisions of G.I. Bill and other laws.

Stimulus to further development of the American Nurses' Association Professional Counseling and Placement Service, Inc., through national, branch, and state offices.

Shift of Red Cross nurse recruitment duties to hospitality and information for returning nurse veterans.

New responsibilities for those in administrative or leadership positions.

Imperative need for thorough-going studies, as proposed by National Nursing Planning Committee, on which to build for the future.

Premium on vision, imagination, and flexibility in guiding nursing into the postwar era.

Growing recognition that no return to prewar era is possible; that a spiral, not a circle, is the course for any profession that has spring or lift to it.

COMMITTEE ON INDUSTRIAL PRACTICE

Los Angeles Industrial Health Program Praised By U. S. Chamber of Commerce

The program sponsored during the war by the Los Angeles Chamber of Commerce is cited by the U. S. Chamber of Commerce as an outstanding accomplishment in the improvement of industrial health.

In a leaflet, *Industrial Health—A Tale of 3 Cities*, the programs in Los Angeles, Williamsport, Pa., and Philadelphia are described. Probably the most important contribution to the success of the Los Angeles program was the leadership shown by businessmen and officials of health agencies in pooling the services of several agencies in a single program.

Because the pattern followed in Los Angeles is an interesting one and because it is adaptable to any California industrial city, the section dealing with the program is reproduced below.

"Los Angeles, one of the great centers of war production, with its 8,000 industries, has recognized the opportunity for manpower conservation and increased production through the development of health services in Los Angeles plants and a plan of worker health education.

"The program for stimulating industrial medical service in Los Angeles plants was organized through the Industrial Security Section of the City and County War Council, which is housed and staffed by the Chamber of Commerce. Such a program, it was recognized, must have the coöperation of the medical and dental professions and of public health officials. These groups, therefore, were called together and asked to nominate members for an Industrial Health Advisory Council. The council in its final membership included representatives from the Los Angeles County Medical Society, the several dental associations in Southern California, the Los Angeles Tuberculosis Association, and Federal, State, county and city public health officials. This grouping of private and public health agencies made possible the allocation of work to the proper agency and substituted full coöperation for what might have been intergroup competition. . . .

Commenting upon the program, Dr. George M. Uhl, Los Angeles City Health Officer, says, "To the 7,000 pieces in each mailing sent out by the council, there was an average of 200 or 300 replies for further information. The city and county health departments and the Tuberculosis and Health Association made the visits according to the location of the plant and the nature of the subject of the current mailing. The final 'convincer' was the personal contact of these field workers meeting with management."

One accomplishment of the program, omitted from the report, is the part the council played in getting *Unseen Enemy*, the radio program on venereal diseases, on the air. This program, sponsored by the State Department of Public Health and local health departments, grew out of the initial broadcasts of the council.

CALIFORNIA PHYSICIANS' SERVICE†

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* * *

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A. E. Larsen, M.D., Medical Director
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Beneficiary Membership

	November, 1944	*November, 1945*
Commercial Program	101,000	152,084
Rural Health Program	2,038	2,133
War Housing Program	15,000	3,799
	118,038	158,016

The Board of Trustees held the regular meeting on Sunday, December 9, 1945, and there were present: Trustees Chester L. Cooley, C. Glenn Curtis, J. Frank Doughty, Donald D. Lum, H. Randall Madeley and A. E. Moore.

There were also present: Doctors A. E. Larsen, G. D. Delprat, and Messrs. Hartley F. Peart, Howard Hassard, W. M. Bowman and R. W. Lyon.

Dr. Delprat, Chairman of the Fee Schedule Committee, appeared before the board to discuss the current status of the revision of the fee schedule. After considerable discussion it was felt that the schedule could be further improved upon before final acceptance. It was the expressed wish of the board that the committee, set up by the board of trustees, was for the purpose of getting the reaction of the profession generally and those specifically from physicians who are not officially connected with C.P.S. The schedule would thus represent changes coming from an independent committee and not from a board of trustees arbitrarily making decisions.

In order to bring the committee and the board closer to an understanding it was moved that a special meeting be held, with the fee schedule committee sitting with the trustees, to discuss in detail the proposed new fee schedule.

In the interest of further increasing the efficiency in the operations of C.P.S. under its new accounting system, which has recently been installed by the office accountants in consultation with the Certified Public Accountants retained by C.P.S., it was moved that all professional members be notified that bills must be submitted within 90 days after the month service is rendered. This had become necessary because the hidden liability of outstanding bills seriously affects business operations. The beneficiary members will also be notified that no claim on their part may be accepted unless they are submitted within a period of three months after a service has been rendered.

On acquisition, it was reported that the October enrollment was 10,107 new members, and November produced 17,382, making a total for the two months of 27,489 persons. The net gain, however, was only 2,349 due to labor turnover, occasioned by unsettled labor conditions.

The offering of C.P.S. membership to physicians and their office staffs produced 1,529 persons. This is not as large as was expected or desired. It was suggested that another reopening be held. This will be done some time in the spring of 1946.

Community programs were held at Ventura and Alhambra. These programs brought together business and other interests in the community with the medical profession, and have been highly successful. Similar programs have been contemplated for other areas.

Sixty-six physicians became new professional members during November, bringing the total professional membership to 5,686. One hundred and one physicians reported back from the military service in November and renewed their membership in C.P.S.

Dr. Herbert D. Simpson, Professor Emeritus from the Department of Economics at Northwestern University, with an international reputation in the field of medical economics, spent several days in the offices of C.P.S. gathering material for a report to the National Physicians' Committee. He was particularly interested in the historical and political background of the plan because of his belief, in studying other plans, that these factors are responsible for the difference in basic organization and future objectives. He was also particularly interested in why medical plans have not grown as fast as they should. He expressed the unofficial opinion that this was due to lack of a unified front of the profession as a whole. His reports will be published shortly.

Mr. V. M. Griffin, actuary for the Assembly Health Care Investigating Interim Committee of the California State Legislature, also spent several days in the offices of C.P.S. His interest was particularly directed toward the costs of medical care. He was furnished with extensive past and current material. Special studies supplementing this information will also be made and furnished to the committee.

C.P.S.'s experience during the months of June and July showed an abnormally high use of service. This experience was the result of the war's end and the attending labor unrest and temporary unemployment. This has resulted in people taking the opportunity to have the many corrective procedures performed that were postponed before due to "war urgency" jobs which demanded their full time. It was pointed out that this was not only true in C.P.S.'s experience but in other plans as well; not only in this state but others.

A complete diagnostic and cost analysis of C.P.S.'s experience during these months was presented and it showed the highest experience in the field of elective surgery.

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† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

Hospitalization is becoming an important part of C.P.S.'s activity in the Northern part of the state, accounting now for 14 per cent of the income. Hospital rates are rapidly increasing and show a definite inflationary trend.

The housing program at Marin City was closed as of the end of October. Two ex-service physicians went into private practice in the area to supply the medical need. The Vallejo housing plan will be closed as of January 1, 1946. The Permanente program will probably extend its services from another part of Vallejo to the Chabot Terrace where C.P.S. is discontinuing.

The board was presented with reports of the C.M.A. Study Committee and also from the C.M.A. Advisory Planning Committee. This latter committee requested necessary information "to study and review all phases of C.P.S. including a study of present policy, personnel, operating procedures, finances, public and professional relations, actuarial experience to date and soundness of insurance principles followed in practice." Complete available information relative to these subjects was supplied to the committee.

The board authorized C.P.S. to enter into a reciprocity agreement with other medical service plans throughout the country.

CHESTER L. COOLEY,
Secretary, Board of Trustees.

U. S. Contracts With Doctors to Treat Veterans at Home—Makes Contract With Michigan State Medical Society

Washington, Dec. 28.—(AP.)—Establishing a new policy to relieve its crowded facilities, the Veterans' Administration today announced a contract with Michigan physicians to treat ex-soldiers at home.

The contract is with the Michigan State Medical Society. It provides for its member doctors to treat war veterans whose disabilities are service connected but do not require hospitalization.

New Plan

Another plan nearing final approval would permit veterans to be hospitalized in their own community hospital instead of a Veterans' Administration institution. The Veterans' Administration would pay the bill.

Maj. Gen. Paul R. Hawley, acting surgeon general of the Veterans' Administration, said that if the Michigan plan is successful it will be used in other states.

First Contract

A Veterans' Administration statement said that this is the first time a contract has been signed on a statewide basis for care of veterans by private physicians.

Hawley called it a "stop gap" plan until Veterans' Administration hospitals, with a capacity of 44,000 beds, can be constructed and more hospitals can be obtained from the Army and Navy. This plan is expected to take two years to complete.—San Francisco *Examiner,* December 29.

Veterans' Health: C.P.S. Doctors Propose "Home Town" Medical Program

A program to give veterans with service-connected disabilities "home town medical care" at government expense is expected to be completed within the next 30 days.

The program, already approved by Northern California physicians and expected to be accepted by Southern California physicians Wednesday, is subject to approval of the Veterans' Administration. The plan would allow patients to choose their own physicians.

The proposed standard minimum fee contract between the California Physicians' Service and the Veterans' Administration is virtually identical with one approved by the Veterans' Administration for Michigan. Approval would make California the second state with such medical service.

William Bowman, executive director of the California Physicians' Service, declared 70 per cent of currently discharged veterans are claiming service-connected disabilities, in contrast with 9 to 10 per cent of World War I.

Reason for the higher volume of disability claims in this war, Bowman said, are (1) the first discharges had the longest war service, (2) the war was longer than World War I, (3) many new diseases were encountered, particularly in the tropics, and (4) the global nature of the conflict imposed trying physical conditions.

Bowman said the California Physicians' Service would provide 6,000 physicians for applicants who had been screened for legitimate service-connected claims by staff physicians of the Veterans' Administration.

Aid to Hospitals

Standardized minimum fees would be specified for service, ranging from office calls to operations. Bowman is scheduled to present the contract in Washington, January 7.

General Omar N. Bradley, Veterans' Administrator, in announcing the Michigan contract, said the primary purpose of the program is to ease critical pressure on Veterans' Administration hospitals.

Federal law specifies veterans with disabilities not traceable to military service can be treated only if space is available in Veterans' Administration institutions and they have no money with which to pay a private physician.

For that reason, they are not eligible to participate in the program.

The Advantages

Veterans' Administration officials said, however, according to Associated Press, the plan may lessen demand for government hospital care because:

1. More veterans with service disabilities may be treated in home towns, thus freeing room in admintration institutions for patients with non-service disabilities. Of 88,000 veterans now receiving government care, about 60,000 have non-service ailments.

2. Home-town treatment of veterans reduces the period of hospitalization. When veterans travel long distances to Federal hospitals, they frequently are kept for a month or longer for "observation" while convalescing. At home, they may leave the hospital and still be under observation of their family physicians.

Bowman said the medical profession also was enthusiastic for the plan because it avoids what they regard as the dangers of "socialized medicine" by leaving choice of physician to the patient at a minimum fee.—San Francisco *Chronicle,* December 30.

State Veterans to Get Care in Home Cities—In Coöperation with California Physicians' Service*

Home town medical care will be given to California veterans with service-connected disabilities.

This is provided in a contract signed yesterday in Washington by the Veterans' Administration and the California Physicians' Service.

The veterans will be treated in their home communities, at Federal expense, by physicians of their own choice.

The information was telephoned to the *Chronicle* last night by William F. Bowman, executive director of the Physicians' Service.

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* For editorial comment, see page 4.

The contract was completed by Bowman, Dr. A. E. Larsen, State medical director of the service, both of San Francisco, with Generals Omar Bradley and Paul Hawley of the Veterans' Administration.

Veterans with service-connected disabilities will be saved the inconvenience of long trips to Veterans' Administration hospitals and long periods of treatment and observation away from home.

The contract becomes effective February 1 and makes available 6,000 physicians of the State organization, out of a total of 6,800 private practicing physicians in California.

Medical services will be made available at standardized fees, covering all phases of medical and surgical treatment.

A procedure will be set up under which Veterans' Administration officials will screen applicants for legitimate service-connected claims.

Global War Hazards

Of California's 1,300,000 veterans, 944,000 served in World War II, Bowman said. He stated that 350,000 are veterans of World War I, 16,000 of the Spanish-American war.

Seventy per cent of currently discharged veterans claim service-connected disability, Bowman declared, as compared to 9 to 10 per cent in the last war.

He attributed the higher percentage in this war to length and intensity of the conflict, and the varied hazards of global war.

Bowman said no other State has a comparable problem of veterans' health. A similar arrangement, first in the United States, was made two weeks ago in Michigan but involved only 300,000 to 400,000 veterans, he said.

1,000 a Month

But, he added, California's veterans are increasing rapidly. Veterans' Administration officials would not give an official estimate of the number moving to this State, but Bowman declared the rate is close to 1,000 a month.

By serving veterans in their own communities, he said, local physicians can keep patients under surveillance, if necessary, avoiding such interference with his private life as would occur through service at veterans' hospitals.

Both General Bradley and General Hawley are planning to come to California soon, Bowman said, and have expressed much interest in the home care plan. The California program is expected to set a pattern for the rest of the country in veterans' care.

Veterans' Administration officials, believe the plan will eventually free existing veterans' facilities for treatment of illnesses not contracted in the services. A large part of present facilities are so used for non-service-connected disabilities.—San Francisco *Chronicle*, January 9.

Los Angeles County Hospital Load Sets Record

During the week of December 10, the patient load at the Los Angeles County General Hospital had reached a total of 3,033, the highest in the history of the institution, according to a report on file with William A. Smith, chairman of the Board of Supervisors.

Superintendent Will in his report explained that private hospitals now are taxed to capacity with the result the county institution is receiving many emergency cases that otherwise might be cared for elsewhere.

The world is like a board with holes in it, and the square men have got into the round holes, and the round into the square.

—Bishop George Berkeley, (*Punch* is responsible)

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Pre-Legislative Maneuvers at Sacramento

Political Groups in Sacramento Prepare For Special Session

Sacramento, Jan. 5.—California's 1946 campaign was off to an early start on January 5, with Governor Warren polishing up his message to the special session of the Legislature, beginning Monday, January 7, and just a few blocks from the Capitol a State-wide group of citizens interested in promoting a postwar program was holding a meeting of its own.

Predictions by Speaker Charles W. Lyon of the Assembly and others indicate that consideration of the 53 items submitted to the lawmakers by the Governor will require from six to eight weeks.

Some legislators even suggested it may be necessary to recess until after the June 6 primaries if the programs of "reconversion" measures are not disposed of by the Senate and Assembly before campaigning begins early in March. . . .

Early arrivals among the legislators had little knowledge as to who will handle the individual bills to be introduced and supported by the State administration. Some of the Governor's friends feared the Warren group might fumble the legislative ball again by failure to have key measures ready for introduction in the Senate and Assembly. This would enable some of the anti-Warren lawmakers to grab some of the more important bills and dump them into the legislative hopper. . . .

The Governor steered away from demands he reopen the compulsory health insurance controversy which marked the 1945 regular session.

Instead he called upon the Legislature "to consider and act upon legislation to provide for sickness and disability payments to unemployed persons." Payments, it is contemplated, would be made out of the unemployment insurance reserves of the State. . . .

A careful perusal of the list of topics submitted by the Governor indicates he will have stolen considerable political thunder of his prospective opponents if he can obtain legislative approval of his program.

The inclusion of some of the items also shows the Governor is not completely oblivious of the fact that an election is just around the corner.—San Francisco *Chronicle*, January 5.

Governor Warren's Plan for Spending Surplus Fund

Sacramento, Jan. 5.—Governor Warren will support a program of postwar fund appropriations of around $227,000,000 at the special session of the Legislature, beginning Monday, January 7.

The Governor's ideas of spending the $235,000,000 extra money in the State Treasury differ considerably, he said, from those of some of the legislators.

Breakdown of Items

If the Governor's ideas are followed, this is about the way the surplus funds will be allocated:

$154,000,000 for State construction purposes at hospitals, colleges, institutions, prisons. . . .

$7,000,000 for a new medical center with hospital facilities, nurses' quarters, etc., at the University of California at Los Angeles.

$4,000,000 for expansion of the University of California's medical center at San Francisco.

$1,650,000 for taking over the U. S. Hammond General

Hospital at Modesto as an emergency institution to relieve crowded conditions in various State hospitals. . . .

$5,000,000 for housing, and $10,000,000 for urban redevelopment.

The Governor's program would leave but a small slice of the $90,000,000 item put aside at the last session. . . .

Governor Warren told newsmen there still would be needed an appropriation for child care centers if these are to be continued after March 12 when Federal funds will no longer be available to aid in financing the centers, a wartime growth.

The Governor contends that "obligations of the Legislature and myself" must be to provide funds for State responsibilities and to carry forward projects to which the State is already committed. . . .

Likewise, he will support a full employment bill and legislation to provide for sickness and disability payments to unemployed persons.

Warren believes the $735,000,000 unemployment insurance reserves will be "ample for all foreseeable needs." It would be from these funds that the sickness and disability payments would be made. — San Francisco *Chronicle*, January 5.

Items in Governor Earl Warren's Call for Special Session of California Legislature Having Medical or Public Health Relationships

Governor Earl Warren issued a call for a special session of the California Legislature to convene in Sacramento on Monday, January 7. Fifty items were placed in the call, each to receive consideration. At a special session of the Legislature, matters not related to items issued in a call cannot be considered.

The fifty items listed by Governor Earl Warren contain several that have direct or indirect relationship to medical practice or public health. These items follow:

1. Housing. Legislation necessary to meet the emergency situation, including any appropriations required.
2. Child care centers.
3. Creation of a hospital survey commission and an appropriation for its activities.
4. Establishment of a medical school of the University of California at Los Angeles.
5. Authorization to State Compensation Insurance Fund to acquire and own real property for branch offices.
6. Authorization for the State to pay counties for service rendered in inspecting boarding homes for aged persons and for children.
7. An increased appropriation for the Department of Mental Hygiene to finance additional outpatient clinics and the maintenance of a new temporary State hospital.
8. Increase in the amount allowed to be paid by the Department of Mental Hygiene for the boarding of mental patients in boarding homes.
9. Appropriation to State Health Department for Mosquito abatement.
10. Legislation for the State to regulate disposal of ship garbage to curb hoof and mouth disease.

C.M.A. CANCER COMMISSION

Cancer Program for California

State Society Adopts 10-Point Plan for Research

A better deal for the cancer sufferers of California is in the making as result of a recent meeting in the offices of the California Medical Association of a group of leading physicians of the California Division of the American Cancer Society with Mrs. Ryer Nixon, State commander of the Women's Field Army at the San Francisco headquarters.

A 10-point program was adopted by the California Division following a report from the American Cancer Society that money raised in the April campaign will be used for reseach, service to cancer victims, and broader education aimed at better understanding of the disease.

The California program will provide for terminal beds in recognized hospitals for the care of incurable patients who are unable to obtain such care in their own homes or to pay for it in a hospital; financial assistance to approved clinics; payment of salary of nurse for cancer cases connected with the Visiting Nurses' Association; financial assistance to doctors wishing to take refresher courses given in San Francisco and Los Angeles hospitals; provision of materials for free cancer dressings to be given to out patient clinics and Visiting Nurses' associations; provision of educational printed matter for distribution; transportation of indigent patients to and from clinics when approved by Public Welfrae; grants for clinical studies to hospitals and universities; endowed beds for operative cases; and the making and distribution of films of educational value on cancer facts.

Some of this program is already in effect. It will be financed by the 60 per cent of the funds that will remain in the State after the April drive . . . the remaining 40 per cent will be sent to the national organization to be used in research under direction of a professional board.

Dr. Lyell C. Kinney, of San Diego, chairman of the board, told of chemical compounds developed through the army's chemical warfare activities, which have been found to have a very considerable effect on malignant growths, causing at least temporary improvement in one type of cancer.

"There are hundreds of other chemicals which should be tried, thus opening an entirely new type of study," he said. "Information on nuclear energy will also be used in the search to find some way to use radioactivity to destroy cancer without injuring normal tissue."

Other findings of the American Cancer Society reported at the meeting were the need for at least 10,000 more beds for the care of cancer patients, 165,000 of whom die annually, and the need for more education on cancer through school text books. Dr. Kinny earnestly supported the plea made at the national meeting held recently in Chicago for "better and more humane care of the terminal cancer case."

Present at the San Francisco meeting last Saturday, in addition to Dr. Kinney and Mrs. Nixon, were other members of the Cancer Commission of the California Medical Association, including Drs. David Wood, Harold Brunn, William H. Daniel, Orville Meland, James F. Rinehart, George Sharp and Henry Ullman and Judge C. J. Goodell.—San Francisco *Chronicle*, January 9.

What the Public Knows About Poliomyelitis

Results of a Gallup poll reported recently in the press indicate that the public knows little about the much publicized disease, poliomyelitis, and what is known by many people is wrong.

About one-third (30 per cent) of the people interviewed have exaggerated fears of the disease, believing that poliomyelitis always leaves its victims crippled or paralyzed.

Only half of the people thought infantile paralysis is communicable, 29 per cent thought it definitely was not communicable and 22 per cent had no opinion.

Replies to the question, *"What do you think causes infantile paralysis?"* in order of mention are: Don't know, 48 per cent; germ (virus), 25; flies or insects, 9; unsanitary conditions, polluted water, 6; improper diet, malnutrition, 3; improper care, overexertion, weakening of system, 4; nerve defect, 2; inherited, born that way, 1; poor blood circulation, 1; miscellaneous, 7; cause not yet discovered, 2.

COMMITTEE ON MEDICAL ECONOMICS

What Dorothy Thompson Said Concerning President Truman's Health [Sickness] Insurance Message, and Wagner Bill S. 1606

The phrase, "economic bill of rights" has a magical quality like "liberal" and "progressive." Just attach one of those words to a measure, and critics back down as though before a fetish. But in a world where progress moves on crutches conservatism may mean in some cases the last stand of liberty and common sense.

Few "liberals" are likely to reveal the illiberality of part of the proposed Federal health scheme. Some of it is excellent. A widespread hospital construction program is urgently necessary, and for that Government can make the economic grant of credit. . . .

But the main part of the proposed measures—universal compulsory Federal insurance against illness of every wage and salary earner by a tax of 4 per cent on his income up to $3600 will, if past experience elsewhere is a guide, mean vast overpayment for inferior services; that the poor pay for the rich, and not the other way around, and that income which should go for illness prevention in the form of nutrition, clothing and shelter will be forcibly extracted to pay for the results of deprivation.

The only people who will profit will be the new ranks of bureaucrats, two for every physician, supported by the people's contributions. The expenditure for ink will exceed that for iodine.

On the matter of state medical care through enforced contributions there is plenty of evidence. Like Communism and Nazism, it is a German invention arising out of Bismarck's concept of the providential state that would forever prevent revolt by tying the very existences of the people into it.

The state cannot create anything. Wealth is created by producers—industrial workers, management, and farmers. State insurances are a means whereby the state skims off their incomes and gives part back in services, many of which the people are better able to provide for themselves as individuals in coöperative groups.

Under the Administration's plan everyone who works would during the lifetime of his earning power, pay 4 per cent of his income up to $3600. An employee with an income of $2000 per year would pay $80. One with an income of $3600 would pay $144. Everybody working would contribute—perhaps three or four of the same family. Any employee with an income above $3600—a salaried man with an income of $10,000, a movie star with incomes of $200,000—would also pay $144.

In private medicine, completely apart from the many coöperative non-profit group insurance schemes in operation, physicians daily perform millions of dollars worth of free services. Their wealthy patients help finance the indigent. This is not a proper situation, but it is more just than the Government bill.

If the cost of the services offered in return for 4 per cent of annual income are compared with those offered by the many coöperative schemes in existence, the price is exorbitant—as well as compulsory. Mutual non-profit schemes cover, for instance, some 23,000,000 industrial workers. One of these, under which 2,300 companies are insured, provides, for $60 per year, medical care for all workers plus their dependents, in home sickness, accident, hospitalization, surgical services—up to a fee of $150—laboratory fees up to $30 per year—and physicians' care up to five visits.

I myself am in a group insurance which provides hospitalization for my whole family for $24 per year.

Coöperative medical schemes are voluntary, efficient, cheap of administration, and cheap for the participants and could be standardized on a high level. State schemes are bureaucratic, heartless, and open to dangerous collusion between assembly-line physicians and patients at the public cost—as those know who have lived under them. The novelists are the best reporters. Those who think this proposal is "progress" should read "How Green Is My Valley," "Little Man, What Now?" and "Karl and the Twentieth Century" for light.

Self-employed (farmers, for instance) are to pay 5 per cent of their incomes. On $3600 that is $180 per year, or nearly 50 cents a day!

Ordinary bouts of sickness in the average family can be dealt with. The real crises are those that require hospitalization and surgical services, and these usually occur only a few times in one's life. Even as an individual, without benefit of group insurance, one can provide for a limited amount of miscellaneous services, operation costs, and 70 days of hospitalization for as low as $17 per year—depending on age and state of health—through private insurance companies.

Barnum said a sucker is born every minute. Along with the sucker is born a politician, and nowadays a "progressive" to beat his drums for every measure that extends the power of the state, even into the most intimate parts of life.—San Francisco *Chronicle,* December 21.

What Eleanor Roosevelt Said Concerning President Truman's Health [Sickness] Insurance Message, and Wagner Bill S. 1606

Hyde Park, Nov. 23.—I have signed today an endorsement of President Truman's health message. There is only one point that seems to me not quite to coincide with our practice in other things. For instance, you pay school taxes only up to a certain percentage of your income. You pay taxes according to the size of your income. Furthermore, no matter what your income may be, you can send your children to public school, and it seems to me that the same should apply in the case of these new health services. The proposed tax is to be 4 per cent of incomes up to $3600 a year. No matter how much income we have, only that amount, apparently, is taxed for this plan; and only people with that income, or less, are expected to make use of it.

Taxes for Health

Unless the health needs of the people as a whole can be met by this tax on a portion of the national income, it would seem to me entirely fair to expect to be taxed in proportion to our income, just as we are taxed for education. In some places the school tax may be based on real estate instead of income, but at least everyone pays the same ratio to his possessions. It seems to me that those of us who have more income or more land, whichever the basis of the tax, should pay regardless of whether we use the health plan or not—on the theory that all citizens are entitled to take advantage of any plan which is for the good of the citizens in general. If they do not take advantage of it, that is their choice.

This does not seem to me to have anything whatever to do with socialized medicine; and I am particularly glad that the proposed plan recognizes the need for giving help to our medical schools, since research and education are essential to keeping up the standards of medical care. This may make it possible for young doctors to work in rural communities, where medical care has been very inadequate in the past.

Valuable Experience

Medical practice is so varied in a rural community that it probably would give invaluable experience to any young man who was willing to put in up to five years in doing this kind of work. It is probably the most exacting kind of work that can be done, and yet it might reach for the first time sections of our country which, from the health point of view, have been almost totally neglected in the past.—San Francisco *News*, November 24.

What Chester Rowell, California Press Commentator Said Concerning President Truman's Health [Sickness] Insurance Message, and Wagner Bill S. 1606

I am venturing this morning to express some individual views on health insurance which come nearer to those of President Truman than those of some of his critics, in and out of Congress. Since my own position on the subject has been notorious for many years, this is merely saying it over again. But the statements and actions of the President and his recommendations to Congress make it an immediate issue, as well as important news.

What the President wants is Federal action, to be worked out by Congress in case it accepts the general policy. This action, he says, is not to be "State medicine," but the extension of existing systems of health "insurance," by prepaid premiums, utilizing existing mediums to distribute the costs of an otherwise unaverageable risk.

This has always been the principle of fire insurance and life insurance, and of the various forms of social insurance which have become increasingly public policy in America. Everybody finally dies. How long each individual will live is unpredictable. He may die tomorrow or he may live to be a hundred or more. But the average expectation is calculable, and is distributed by insurance. The same is true of fire risks, except that some structures never burn. The fortunate owner is the one who pays out his insurance fees and never draws for any losses. The same thing is the case with unemployment, old age, industrial accidents and illness.

The objectors to health insurance, however, on even a State scale, and even more to a Federal one, raise the slogans of "regimentation," and all the rest, and insist that, if any of the money, or even the supervision, comes from "government," it means "political" control of "medicine," both the doctor and the patient. And "bureaucracy," they say, "never lets go."

However, there are certain matters of common arithmetic, as well as the desires of groups, like labor, the returning veterans, small farmers and others, who are going to get what they want, no matter how sincere some of the opponents may be in arguing that they should not have it.

On the arithmetic side, the President points out that 4 per cent of the pay rolls or gross incomes of those under a certain modest minimum is what is now being paid for the costs, medical and otherwise, of illness. This estimate is either correct, or can be ascertained by a fact-finding commission—provided it is composed of fact-finders, competent to find the facts and interested only in finding them.

But here is other arithmetic, which I know, from considerable first-hand information, to be true of schooling, and which qualified observers insist they can prove is true of medical care and hospitals also. . . .—San Francisco *Chronicle*, November 22.

What Newspaper Editors Said Concerning President Truman's Health [Sickness] Insurance Message, and Wagner Bill S. 1606

Health Insurance

We have long supported the effort to establish a health insurance system in California. We believe a medical care program should be operated by the individual states and not by the Federal Government. We have a profound distrust of remote control by a vast Washington bureaucracy of a concern touching so intimately the lives of the citizens.

Our lack of confidence in the plan President Truman proposes is not made less by the language in which he describes it. On May 28 of this year we suggested to the California Legislature that it take careful note of Senator Wagner's then proposal of a vast Federal health insurance operation as a threat hanging over the State if it failed to install its own program. We then said that if there were no other defects immediately apparent in the Wagner scheme the language in which the New York Senator urged it would alone arouse deep suspicion.

We now find it is Wagner's sleeping plan which is revived to be brought before Congress at this moment and that in urging it President Truman has only echoed what Wagner said last spring.

The President repeats Wagner in asserting that this plan is not "socialized medicine." "Socialized medicine," he said, "means that all the doctors work for the Government." That is only Truman's, or rather, Wagner's definition. There is more than one way of tying a knot. Wagner said it would not mean "regimentation." Any compulsory rule laid on the citizens is regimentation. We could have regimentation in a State system, too; we recognize that, but it is the unfrankness of these declarations that rouse us here. To us these assurances are nothing more than attempts to soothe persons who do not like the terms "regimentation" and "socialized medicine." They should not fool anyone who can put two and two together.

Similarly unfrank semes the President's assertion that the system must be "highly decentralized in administration" though the fund "should be built up nationally." These two elements are completely incompatible. Whoever holds the purse runs the show and from the place where the money is held. Nothing run by Washington is ever decentralized. OPA is a good example; it is supposed to be decentralized with district and local administrators, but anyone who has had dealings with it knows every new question has to be referred to Washington. In other words, you can't decentralize centralization.

We agree that a health insurance program should be decentralized. In our opinion the best and only chance of a degree of decentralization lies in state-run health insurance systems. Who wants to wait on Washington to decide whether his particular kind of case is in the rule book?

We assume it is only to catch the doctors that the President spreads the molasses of "more money for all of them." We are unable to calculate how this could be on the basis of the President's statement that the requisite 4 per cent tax to raise the fund is only about what Americans now spend for sickness care.

We do not want another national bureaucracy to create another huge pressure group in Government.—San Francisco *Chronicle*, November 21.

What Union Labor's Representatives Said Concerning President Truman's Health [Sickness] Insurance Message, and Wagner Bill S. 1606

CIO Backs Truman on Health

President Truman's call for a national health program this week won full support of the national CIO, expressed by CIO President Philip Murray. Murray declared:

"The CIO lends its hearty support to the general principles set forth in President Truman's special message proposing a 5-point national health program.

"It has long been apparent to the CIO that a national health insurance system for prepayment of the costs of medical care is a necessary next step. We have indicated our willingness to consider the participation of voluntary organizations in the insurance system, but favor the general principle of compulsory insurance as necessary to nationwide coverage."

Murray's endorsement of the Truman message to Congress contrasts sharply with the "Yes, but—" answer of the California Medical Association, which says it likes the objectives embodied, but opposes "government compulsion" and "regimentation."

"We congratulate the President on his statement with respect to the construction of hospitals and related facilities," said Murray, "and for saying that in approving state plans and individual projects and in fixing the national standards, the Federal agency should have the help of a strictly advisory body that includes both public and professional members.

"The CIO has already endorsed the Kilgore bill (S 1297) for scientific research. We are also on record as supporting the related provisions in the Wagner-Murray-Dingell bill (S 1050)."—San Francisco *Labor Herald*, November 30.

What Insurance Underwriters Said Concerning President Truman's Health [Sickness] Insurance Message, and Wagner Bill S. 1606

Expect Defeat of Plan

San Francisco A. & H. Underwriters See Truman's Proposal as Far-Reaching; Predict Rejection

The proposal by President Harry S. Truman on Monday (Nov. 19) of a five-point national health insurance program aroused vigorous comment throughout the San Francisco insurance district, but the general consensus was that the plan presented to Congress has little chance of passage.

The program, which is held to be much more far-reaching than the State health proposals under consideration in California, would provide the following:

(1) Federal aid for construction of hospitals, health centers and other facilities where they are needed.

(2) Increased use of Federal funds to expand coöperative State-Federal public health, maternal and child health service.

(3) Federal aid to support more adequate professional education and the advancement of research on the cause, prevention and cure of cancer and mental illness.

(4) A compulsory national health insurance system to assure pre-payment of medical costs under a plan which would leave patients free to choose their own doctors and hospitals.

(5) Disability insurance for protection against loss of wages because of sickness and disability.

It was by the inclusion of the latter point that observers saw in the President's proposal a plan more far-reaching and one that more seriously affects private carriers than the current suggestions for similar State legislation in California.

Optimism that the measures will either be defeated or will be so modified as to remove most of their objectionable features, was generally held among insurance executives. This was based upon the fact that the President is encountering increasing difficulty in getting many of his major proposals through Congress, and, more particularly, by the fact that only recently has Congress rejected a measure to increase the scope of the existing Social Security law.

The measures proposed by the President are reported to involve an additional payroll tax of four per cent on people whose incomes are below the $3,500 mark. Not a few A. & H. executives pointed out that at this cost almost any good risk could now secure full coverage on a non-cancellable policy for less money.—San Francisco *Underwriter's Report*, November 22.

Another Payroll Deduction?

There is no doubt that the American people—especially the people of California, where 1,500,000 citizens already are enrolled in voluntary pre-pay medical care systems—are health insurance "minded," as the phrase goes. So perhaps the fact that President Truman's plan for national compulsory health insurance would have to be financed by the heaviest paycheck cut on American workers since the withholding tax was invented may be the chief reason why the plan has met with no noticeable public enthusiasm.

A payroll levy of 4 per cent has been estimated by Washington statisticians as the minimum for carrying out the national plan. That would more than cancel out income tax relief hoped for next year! For example, a married man with two dependents, earning $3000 a year, will pay $250 in withholding taxes in 1946, including $60 for Social Security and unemployment insurance. Four per cent for compulsory health insurance would take an additional $120 from him—boosting his total tax by nearly 50 per cent!

The public has come to a rightful conclusion, from experience, that government-financed programs are always inordinately costly—what with the inevitable excessive overhead of overmanned administrative staffs.

Californians, with access to voluntary health insurance systems which are proving to be eminently satisfactory, both in cost to the enrolled individuals and families and in the caliber of medical and hospital service, have shown marked coolness toward plans of the compulsory type. None of several bills proposing them for this State even got out of committee at the last legislative session.

The President's plan seems in for hard sledding.—Salinas *Californian*, December 1.

Why Not the State?

Now President Truman has made a five-point proposal in the interest of a national health program. In a recommendation to Congress he asks for Federal aid for construction of hospitals nation-wide, for the creation of health centers and for other facilities that may be needed to carry out his proposal. Increased use of funds to expand coöperative state and Federal public health is emphasized. Also money will be needed to support more adequate professional education and the advancement of research on the cause, prevention and cure of cancer and mental illnesses. A compulsory national health insurance system appeared in the President's program but with the assurance that patients will be "free to choose their own doctors and their own hospitals." The Chief Executive foresees that in this movement there will be an increase in economic productivity in direct ratio to the improvement in the national health.

Governor Warren sought to interest the public and the Legislature in a similar movement but his outlined plan did not receive full sanction of the State nor of the Legislature. The reaction to the President's proposal will be awaited with interest.

But in the meantime the nation will not fail to note that the public debt has reached roundly the sum of $300.-000,000,000. Not only that, but the cost of government is today far beyond the government's income. How shall we finance the additional burden which the President now proposes?

And as a matter of fact, if health insurance is to find favor should it not be fathered by state authority rather than by the Federal Government? Administration will prove intricate and expensive; it certainly can be controlled more effectively with each state acting for itself than through Federal Government with headquarters in Washington and with state headquarters established in the commonwealths of the Union.

If this nation is to get back to normal it must be through a reorganization of the national government. Obviously we cannot make progress from year to year if maintenance is in excess of income, while in addition we still have that enormous debt to consider.

President Truman emphasizes that his plan would not amount to socialized medicine, that people would be free to follow their own inclination as to doctors and hospitals. That might make for support of the proposal but it does not solve the problem of finances. How can we spend more millions or billions, perhaps, in carrying out the President's program so long as we are billions in debt and with the prospect that that debt will increase rather than diminish in the postwar years? Isn't it a job for each state rather than for the nation?—Bakersfield *Californian*, November 20.

The President's Health Program

President Truman's message to Congress on a national health program presents the usual array of arguments used by the proponents of compulsory health insurance. There is the familiar insistence that it doesn't mean socialized medicine and the conventional gesture toward permitting voluntary coöperative organizations to participate "if they can contribute to the efficiency and economy of the system."

The presentation of broad generalities as to the need for more and better health and medical facilities is one thing; the translation of them into law short of socialization is another. California's recent experience with the various compulsory health insurance proposals exemplified this.

At first glance one would think that doctors who frequently find difficulty in getting their pay would welcome relief on this score. But many doctors nevertheless conscientiously oppose compulsory systems which they see as leading toward regimentation of their profession and the leveling off of the quality of service as the spur to individual incentive is dulled.

They may be wrong but thus far the record of American medicine when set against that of countries which have compulsory systems has not suffered by comparison.

There are so many different angles to the entire problem that generalities tend to oversimplify a highly complex problem. It is trite to say that no amount of money alone can buy good health. But it is true. The members of the medical profession themselves will be among the first to admit that they have not the answers to many of the problems involved in the mental and physical ailments which afflict mankind.

President Truman mentioned the Selective Service examination record but he did not analyze it from the standpoint of (1) either the lack of opportunity for proper care, or (2) whether medical care alone would have materially changed the picture. . . .

The recital of the causes of these rejections at least tends to accentuate the complexity of the problems involved in a health program. Paradoxically many of these 4-F's will be active and alive after their more healthy brethren have passed away.

The Federal Government through public health measures, through aiding in the provision of needed hospitals and medical centers and in other broad ways can undoubtedly do much toward improving health standards. To the extent that it helps voluntary systems of prepaid hospital and medical care, it will be promoting a desirable movement which from all indications can be more fully exploited than it has been.

But Congress will be well advised to consider carefully the full implication and impact of a system of taxation and the disbursement of billions of dollars under compulsory health insurance.—Los Angeles *Times*, November 21.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Venereal Disease in San Francisco

Study Shows Psychiatric Facilities Must Augment Medicine for Control

Control of the city's soaring venereal disease rate cannot be effected by proper medical treatment alone. In addition, use of psychiatric facilities offered as part of a mental hygiene program is necessary.

This was the tentative conclusion yesterday of a group of venereal disease authorities and psychiatrists who have just completed an experiment in the psychiatric treatment of promiscuous girls at the San Francisco City Clinic.

The 17-month project was undertaken under joint auspices of the venereal disease division of the United States Public Health Service, the California State Department of Public Health and the San Francisco Department of Public Health.

First Experiment of Kind

The unique experiment, first of its kind in the United States, was undertaken at a cost of $18,000, to determine the personality and environmental factors motivating the promiscuous behavior of a group of girls; to assist them in making satisfactory psychological adjustments, thus removing the likelihood of their behavior leading to dissemination of venereal disease.

Dr. Ernest G. Lion, director of the experiment, emphasized that prostitutes were not included in the study and that promiscuous patients included married women who had indulged in extramarital relations.

365 Women Involved

An analysis was made of 365 patients, of whom 287 were classified as promiscuous and 78 as potentially so. Eighty per cent were white and the remainder chiefly Negro. Average age of the patients was 20 years, and 90 per cent of the group was referred by the city's venereal disease clinic and the rest by other medical agencies of the city and the Juvenile Court.

Dr. Lion, who was assisted by Helen M. Jambor, Hazle G. Corrigan and Dr. Catherine P. Bradwal, determined that no single factor was found in itself either denoted or excluded promiscuity.

Basic contributory factors seemed to be unsatisfactory family relationships, often marked by broken homes and unstable personal relationships. In addition, the survey disclosed, sex instruction which the patient had received usually was described as being inadequate and unscientific. Uneven development in physical, emotional and social maturity within the individual usually was noted.

Environment Big Factor

Environment factors, such as unsatisfactory living conditions, absence of community ties and the making of casual friendships often were found to have contributed to the promiscuous behavior, the report showed.

Response of the patients to the service offered varied. No significant differences were found as to use of the psychiatric service on the basis of age. In general, the survey showed, the proportion of patients who took advantage of the service increased as the intelligence level rose.

Some Not Interested

Approximately one-sixth of the patients referred to the clinic availed themselves of intensive, prolonged treatment. An additional one-half of the patients utilized consultive service. Slightly more than one-third were not interested.

"Changes observed in patients during the course of treatment suggested they had benefited from the services given and in particular had reduced their promiscuity," the report stated.

"Only 40 per cent of the patients could be successfully followed up after six months. The number was too few for conclusive deductions, but among those successfully followed, 90 per cent were less promiscuous and 50 per cent had ceased sexual relations outside of marriage."

Medicine Not Sufficient

Although reluctant to offer any specific suggestions on the basis of the experiments, Dr. Richard A. Koch, chief of the Division of Venereal Diseases of the San Francisco Department of Health, declared that medical treatment alone for venereal diseases is not enough.

The experiment demonstrates only, he said, that this type of psychiatric aid should be part of any community's mental hygiene service that in turn is an offshoot of a public health department.

Of particular importance has been the availability of service to patients in meeting the emotional experience associated with venereal disease at a time when anxiety has been aroused by the presence of or probability of a venereal disease.

Other Centers Desired

As a result of the San Francisco experiment, Dr. J. R. Heller, Jr., chief of the United States Public Health Services Venereal Disease Division, is recommending establishment of five similar centers in various metropolitan areas.

Whether the San Francisco service will continue will depend upon Federal, State and city appropriations.

Present at a conferense held on October 3, at announcement of the experiment's conclusion were Dr. J. C. Geiger, San Francisco Public Health Director; Dr. A. Frank Brewer of the State Department of Public Health and Lawrence Arnstein, of the California Social Hygiene Association.

Botulism—Report of an Outbreak in Los Angeles

While a rare disease, botulism has come into the limelight with the increase in home canning associated with victory gardens.

Recently two cases with one death occurred in Los Angeles from home canned chile. Both individuals had merely tasted the chile before frying, and obtained enough toxin to kill one. The life of the other was undoubtedly saved by antitoxin. Six people who ate the chile after frying remained perfectly well.

Botulism has been reported from 32 different states, although most commonly from the western states: California, Washington, Colorado, Montana, New Mexico, and Wyoming. Of 1,024 cases collected by Dr. K. F. Meyer of San Francisco who has done practically all of the pioneer work in this field, there were 669 deaths, a fatality rate of 65 per cent. He has recorded forty-six different preparations of home canned vegetables, seventeen different canned meats, eight types of canned fish, and three milk preparations as causing outbreaks. Home canned string beans, asparagus, corn and spinach are the commonest sources. No outbreaks of botulism have resulted from commercially canned products since 1925.

Botulism is caused by the ingestion of an extremely potent, heat labile, exotoxin, which is produced under anaerobic conditions by the spore forming bacteria Clostridium botulinum. This organism occurs in the soil. Unless the spore is killed by pressure cooking there is danger of anaerobic growth in the can or jar and toxin formation. If thoroughly cooked for 15 minutes the toxin is destroyed. If merely tasted before cooking, enough toxin may be ingested to cause death. Clostridium botulinum does not develop in an acid media (P.H. below 4.5) and no toxin is developed. The addition of other products, such as sodium bicarbinate may, however, raise the p.h. of "acid food" to a point where toxin will develop. When fed to chickens toxin causes characteristic "limber neck" and death.

Clinically, botulism is characterized by delayed onset (18 to 38 hrs.), muscular weakness, disturbed vision and swallowing. Pain and gastro-intestinal symptoms are infrequent.

Motor Vehicle Traffic Accident Deaths in California and the Nation

How safe you are on the streets and highways of California depends upon where you are. But wherever you are, you are less safe than if you were in many other parts of the United States.

The national death rate for motor vehicle accidents in 1944 was 18.3 per 100,000 population. The California rate was 29.0.

In the 580 cities which report motor vehicle traffic deaths to the National Safety Council, the death rate per 100,000 population was 11.2. Seventeen California cities are included among reporting cities. Their rates for motor vehicle traffic accidents are given below:

City	*Death rate per 100,000*
Berkeley	18.0
Beverly Hills	13.4
Glendale	8.8
Long Beach	18.9
Los Angeles	21.0
Oakland	24.8
Palo Alto	11.8
Pasadena	6.7
Richmond	33.1
Riverside	25.0
Sacramento	9.5
San Bernardino	15.6
San Diego	19.2
San Francisco	15.6
San Jose	25.3
Santa Monica	30.4
Ventura	45.1

Throughout the nation, nearly 60 per cent of all motor vehicle deaths occur in rural areas and in cities of less than 2,500 population. The next highest proportion of deaths (23 per cent) occurs in cities with more than 100,000 population.

In 57 per cent of fatal accidents occurring in 27 States, drivers were reported in violation of the law. Chief violations were: Exceeding speed limit, 16 per cent; on wrong side of road, 7; did not have right of way, 6; under influence of alcohol, 5.

Thirty-three per cent of pedestrians who were killed in motor vehicle accidents were struck down when crossing between intersections, 23 per cent while crossing at intersections, and 18 per cent while walking in the roadway.

All statistics are from *Accident Facts*, 1945 Edition, National Safety Council.

Rheumatic Fever in Los Angeles

Rheumatic fever accounts for 90 per cent of the heart disease that occurs under 30 years of age. It may be transmitted from person to person and frequently occurs in epidemic form in schools and military organizations. Multiple cases may occur in families, as in tuberculosis. culosis.

As in tuberculosis, the incidence is higher in lower income groups living under substandard and crowded conditions. A study of the geographic distribution of rheumatic fever in Los Angeles for 1944 shows the highest incidence in the east Los Angeles area. It is interesting that this same area also has the highest incidence of tuberculosis and diptheria in the city. The next highest incidence of rheumatic fever occurs in the southeast Los Angeles area which also has the second highest incidence of diphtheria and the third highest (there are ten study areas) incidence of tuberculosis.

On the other hand, the Hollywood area which has the lowest incidence of rheumatic fever has also the lowest incidence of diphtheria and the fourth lowest incidence of tuberculosis and Venice area with the next lowest incidence of rheumatic fever has the lowest incidence of tuberculosis and the next lowest incidence of diphtheria.

Worthwhile strides have been made in the control of rheumatic fever. If children can be found in the pre or early heart damage stage steps may be taken to prevent heart damage. Such children should be watched very carefully, however. Protection from upper respiratory infection by various degrees of isolation and chemical (sulf) prophylaxis of these susceptible children have shown promise.

All rheumatic fever cases should be reported to your health department immediately. The Los Angeles Heart Association, the Heart Division of the Los Angeles Tuberculosis and Health Association, and the State Crippled Children's Division are ready and anxious to be of help in preventing permanent heart damage.

Science Credits

Casting up its accounts at the end of the year, science finds it does not lack important setoffs for its atomic bomb. If 1945 produced this menace to mankind it also carried far benefits to humanity in advances in the treatment and prevention of disease.

Dr. Robert C. Miller of the California Academy of Sciences lists a few of the outstanding medical discoveries. One we have heard very little about, promin, a drug which has produced great improvement in the treatment of leprosy. Another is a cure for the dread cholera which is said to be 100 per cent effective. BAL, another recent discovery, is a new remedy for arsenic poisoning.

The public has heard a great deal about DDT, but, naturally enough, with its own gardens in mind, thinks about it chiefly as a destroyer of insect pests. It is that, but more important is the fact that it is an effective exterminator of some of the insects that are the worst carriers of diseases. DDT has proved to be the most capable agent ever found to combat typhus fever, malaria and sleeping sickness, all transmitted to human beings by insects. On some of the once fever-ridden South Pacific isles a malaria mosquito is now said to be a great novelty. It was DDT that stopped the threatened typhus epidemic at Naples and it is DDT that is now being used to make sleeping sickness districts in Africa habitable.

It was a military purpose that speeded nuclear fission to make possible the atomic bomb; it was a military object that gave medical science more progress in the few war years than it might otherwise have made in a generation. BAL was discovered in work on poison gases; the cholera cure was a by-product of studies of blood plasma.

COMMITTEE ON PUBLIC RELATIONS

A.M.A. Council on Medical Service and Public Relations—American Medical Association

The wide range of subjects covered by the first Public Relations Conference of the Council on Medical Service and Public Relations is shown by the following summary of recommendations.

Round Table on Legislation—Moderator, James R. McVay, M.D. The opening and development of the Washington Office was highly commended and its further expansion and continued financial support recommended.

It was further recommended that each state association be invited to appoint a special national legisltaive committee to work with the Council and the Washington Office. The Council was requested to bring a resolution along these lines and in accordance with the suggestions made to the coming meeting of the House of Delegates.

* * *

Round Table on the E.M.I.C. Program—Moderator, Thomas A. McGoldrick, M.D. The Conference unanimously disapproved the present E.M.I.C. bill, S. 1318, and called upon the members of the entire medical profession for personal disapproval. It was recommended that any program of the Children's Bureau be administered through the state medical associations; that the present Advisory and Steering Committee to the Children's Bureau be replaced with a committee consisting of one representative from each state medical association and such other medical organizations as have direct interest in the functions of the Bureau; that the Children's Bureau be transferred to the Federal Security Agency until such time as all health and medical activities are segregated into a single department; that state medical associations have some say in the expenditure of any funds appropriated by Congress for health and medical services; that the American Medical Association take action to bring these resolutions to the proper authorities for action and that every Congressman be personally appraised of the defects and dangers of this bill.

* * *

Round Table on the Public Relations Job—Moderator, John H. Fitzgibbon, M.D. No specific resolutions or recommendations were presented. The round table agreed on the importance of establishing two types of public relations separately, one within the medical profession itself and one concerned with the relations of medicine to the public.

Public relations within the profession was emphasized as a necessary preliminary to public relations with the public and the A.M.A. was urged to intensify this program. It was pointed out that this was particularly true of current medical economic problems and new techniques for public relations were discussed at some length.

Among the techniques and proposals discussed for public relations to the public were: "The Committee on Community Health," "Radio," "The Press," "Motion Pictures," "Special Exhibits." The programs of various state medical societies were presented and discussed. In concluding their report, the committee urged that the Board of Trustees of the American Medical Association give special consideration to the extent to which such public relations services be utilized by the Association. The committee called attention to the fact that it is now generally recognized that the relations of the individual physician to the individual patient are on a substantially sound basis and that antagonism of the public toward organized medicine seems to rest on a basis that the opponents of organized medicine offer and promise complete medical care on what seems to be a relatively small outlay whereas the American medical profession has not yet come forth with a specific program on a nation-wide basis. In concluding the committee pointed out that the task of public relations will be rendered much easier if those concerned could be put in possession of a constructive program which they could promote to the public rather than in a position of a continuous defense of programs coming from other sources.

* * *

Round Table on the Placement of Medical Officers—Moderator, Harold C. Lueth, M.D. The committee recommended that the A.M.A. request the Procurement and Assignment Service and the Navy, Army and the Public Health Service to ascertain at the earliest practicable time the future policy relating to the deferment of medical officers to serve in residences.

With respect to the G. I. Bill of Rights it was recommended that all discharged medical officers be given terminal leave pay at the termination of their active duty and prior to the expiration of such accrued leave as they may have thus enabling them to immediately participate in the benefits of the bill.

It was also recommended that the Bureau of Information of the A.M.A. be established in permanent form to provide information on each physician in the United States, possible locations for physicians, and of physicians who desire change in location.

It was urged that each state establish an information service to collect facts and information so as to be in the position to supply data concerning areas in need of physicians and concerning the complete picture of medical facilities in operation and needed within the state.

It was recommended that the Council on Medical Education and Hospitals be urged to set up at once a method for the more prompt approval of hospitals for residencies and consider the advisability of providing some temporary approval system.

* * *

Round Table on Prepayment Medical Care—Moderator, A. W. Adson, M.D. Voicing the opinion that six per cent of the total population covered by voluntary prepayment plans is insufficient and the hope that a nation-wide plan would assist materially in raising this percentage, the committee recommended a meeting of representatives from the forty-eight states to be held November 30 and December 1 in Chicago. At this meeting the representatives of the states were urged to go thoroughly into the problem and it was recommended that the delegates to this meeting consider the formation of a nucleus for the development of a nation-wide plan in correlation with the plans now operating and to assist those states which do not have plans. Doctor Adson was authorized to act as chairman and call the proposed meeting.

* * *

Round Table on Rural Health—Moderator, F. S. Crockett, M.D. The round table on rural health did not present recommendations or resolutions. It was the considered opinion of this group that the work on rural medical service is so new that no fixed opinions could be given as to what must be done or as to the needs. The coöperation of all of the states and more active interest in the problem was urged.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Man-Made Cosmic Rays

4,000-ton Cyclotron at University of California Campus in Berkeley May Permit Their Artificial Production, the Obtaining of Atomic Energy from Cheaper Sources and the Discovery of Many New Elements

Breaking the war-imposed silence which has shrouded atomic research since 1941, Prof. Ernest O. Lawrence, University of California physicist and Nobel prize winner, disclosed that work has been commenced on a $1,450,000 project which will provide the university with a gigantic 4,000-ton cyclotron, three times larger than any now available, for use in peacetime atomic exploration. The machine, which will be completed next summer, may for the first time permit the artificial production of cosmic rays, the obtaining of atomic energy from cheaper sources than uranium, and the discovery of many new elements, Dr. Lawrence predicted.

The youthful-appearing scientist was frankly elated as he announced that military authorities had flashed a green light to "go ahead with unhampered peacetime atomic research."

"Certain security restrictions will continue in effect," he said, "but I believe we shall be able fully to publicize our activities in the very near future."

For the present, though, Dr. Lawrence added, American researchers must confine their experiments to this country, not exchanging findings or data with scientists of other nations.

"I find no fault with these security restrictions," he emphasized.

Construction of the 4,000-ton cyclotron began in 1940, Dr. Lawrence continued, but was halted two years later to permit use of the equipment already installed for production of the first sizable portions of U-235 pure enough for use in the atomic bomb.

When completed the giant atom-smasher will be five times more powerful than the present 60-inch Berkeley cyclotron, which was also a top-secret wartime project when it was employed in research on the bombs that leveled Nagasaki and Hiroshima. The new 184-inch cyclotron was originally designed to produce deuterons (heavy hydrogen nuclei) of 100,000,000 electron volts, Dr. Lawrence said, but knowledge gained in war research has resulted in plan changes which will permit physicists to accelerate deuterons to energies of 200,000,000 electron volts and alpha particles (helium nuclei) and protons (hydrogen nuclei) to energies of 400,000,000 electron volts. However, he added, the machine, which includes a 3,700-ton electromagnet—the largest known to exist—will initially be capable of producing deuterons with energies of 60,000,000 electron volts and alpha particles of 120,000,000 electron volts. These are merely words to the average layman but to Dr. Lawrence and his associates they spell the opening of broad new fields for research from which radical changes affecting all human life may develop.

"The enermous energies which will be achieved will make practical the heretofore impossible testing of many theories of atomic structure," Dr. Lawrence stated. "Nobody knows what the ultimate results will be, but this laboratory will be open 24 hours a day, seven days a week, constantly pressing the quest for new knowledge."

Operation of the giant atom smasher, he declared, will bring science into a "new realm of the atom."

"We shall be breaking through a new barrier," he said. "What we find beyond should be as exciting as what we have found since the 1930's, when we began breaking into the nucleus of the atom. That we shall learn more of the elementary forces of nature is almost certain. The opportunity will exist for mankind to gain greater control of our environment through the use of this information."

The research machine will provide new tools for research in biology, medicine, chemistry and agriculture, Dr. Lawrence pointed out.

Prof. Wendell M. Latimer, Dean of the University of California college of chemistry, and Prof. Glenn T. Seaborg, one of the discoverers of plutonium, said they hoped it will be immediately possible to use the device to produce new trans-uranic elements, four of which have been obtained by combined processes of bombardment in the 60-inch cyclotron and chemical separation.

The promised artificial production of cosmic rays is significant, Dr. Lawrence pointed out, because scientists presently pin their hopes of eventually understanding the nature of matter on these rays.

Cosmic rays, he added, are believed to result from explosions in nature releasing atomic energy. Laboratory production of them will permit a constant study, he explained, as contrasted with the present limitation which permits study of chance cosmic rays only as they pass through instruments such as cloud chambers.

"Such fundamental research is necessary if we are to understand the forces with which we are working," Dr. Lawrence declared. "While we know how to produce the atomic energy in a bomb, we know very little about the elementary nuclear forces involved in the release of atomic energy."—*Science News Letter*, December 22, 1945.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Headquarters, Hotel Biltmore, 5th and Olive Sts. Dates of meetings: Tuesday, May 7-Friday, May 10, 1946.

American Medical Association. The next annual session of the American Medical Association will be held in San Francisco, July 1-5, 1946. (Monday-Friday, inclusive.)

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in CALIFORNIA AND WESTERN MEDICINE for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576. Also, August, 1945, CALIFORNIA AND WESTERN MEDICINE, pp. 61-62.) On p. 61 (C.M.A.) and p. 62 (A.M.A.)

Medical Broadcasts*

The Los Angeles County Medical Association:

In January, KFAC will present broadcasts on Saturdays at 10:15 a.m.: January 5, 12, 19 and 26.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

For radio broadcasts of "Doctors at War" by the American Medical Association, see *J.A.M.A.*

Pharmacological Items of Potential Interest to Clinicians*:

1. *Interesting Books:* E. S. Russell's *Directiveness of Organic Activities* sounds good (Cambridge Press, 204 pp., $2, 1945). So does E. Huntington's *Mainsprings of Civilization* (Wiley, N. Y., 1945, 672 pp., $4.75). Ditto for N. Cousins' *Modern Man Is Obsolete* (Viking, N. Y., 1945, 59 pp., $1). Also ditto for A. L. Kroeber's *Configurations of Culture Growth* (Univ. California, Berkeley, 1945, 832 pp., $7.50). And B. D. Panth's *Consider the Calendar* (Columbia, N. Y., 1945, $1.25). Also A. H. Leighton's *The Governing of Men* (Princeton Press, 1945, 420 pp., $3.75). Be sure to read C. L. Becker's Cook Lectures at Michigan: *Freedom and Responsibility in the American Way of Life* is a pertinent last testament applicable to us all (Knopf, N. Y., 1945, xlii and 121 pp., $2.50). R. B. Perry's *One World in the Making* offers worthy challenge (Current Books, N. Y., $5, 275 pp., $3). B. Russell pot-boils vigorously in *A History of Western Philosophy* (Simon Schuster, N. Y., 1945, 895 pp., $5). I. S. Kleiner's *Human Biochemistry* is welcomely concise (Mosby, St. Louis, 1945, 573 pp., $6). H. H. deJong discusses *Experimental Catatonia: A General Reaction-Form of the Central Nervous System* (Wms. & Wilkins, Balt., 1945, 225 pp., $4). Wms. & Wilkins also offer W. J. Hamilton, J. D. Boyd and H. W. Mossman's *Human Embryology: Prenatal Development of Form and Function* (Balt., 1945, 366 pp., $7). L. E. Hinsie psychosomaticizes in *The Person in the Body* (Norton, N. Y., 1945, 263 pp., $2.75). J. G. Horsfall's *Fungicides and Their Action* should be useful (Chronica Botanica, Waltham, 1945, 239 pp., $5). Important is J. Felsen's *Dysentery, Colitis and Enteritis* (Saunders, Phila. 5, 1945, 618 p., $6). Surgeons and obstetricians should welcome I. Chavez's *Enfermedades del corazon: Cirugia y embarazo* (Colegio nacional, Mexico, D. F., 1945, 182 p.). Appropriate to the Roentgen centennial and to x-ray semi-centennial is O. Glasser's *Dr. W. C. Roentgen* (Thomas, Springfield, 1945, $4.50). C. C. Thomas also issues J. Adriani's *Chemistry of Anesthesia* (Springfield, 1945, $7). Watch for C. C. Thomas's *American Lecture Series.* Worthy text is E. Altenburg's *Genetics* (Holt, N. Y., 1945, 452 p., $3.25). F. C. Waite well tells *The Story of a Country Medical College: A History of the Clinical School of Medicine, Woodstock, Vermont, 1827-1856* (Vermont His. Soc., Montpelier, 1945, 213 p., $4.50). O. A. Bogomolets' *Influence of ACS on Healing of Fractures* offers English summaries, as do most current Russian medical books (Kiev, Acad. Sci. UK SSSR, 1944, 195 p.). Provocative is G. K. Khrushchov's *Role of Leucocytes in Reparative Processes of Tissues* (Moscow Academy, 1945, 116 p). Finally ready for distribution is *The Manual of the M. D. Anderson Hospital for Cancer Research*, and it's well done (Houston, 1945, 201 pp.). D. Guthrie offers a short *History of Medicine* (Nelson, London, 1945, 448 p., 30s).

2. *Antibiotics:* Sir Howard (Nobelate) Florey's Lister Lecture to Royal College of Surgeons on Oct. 11 well reviews history of antibiotics (*Lancet*, 2:503, Oct. 20, 1945). E. E. Hays and large St. Louis Co. confirm C.

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† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week. In CALIFORNIA AND WESTERN MEDICINE, some rosters appear in every second or third issue.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

Bouchard's observation of antibiotics (Compt. rend. Acad. 108:713, 1889), from Pseudomonas aeruginosa (B. pyocyaneus) and obtain them in crystalline, potent, and non-toxic form (*J. Biol. Chem.*, 159:725, 1945). Merck's N. G. Brink & Co. offer interesting data on chemical relations of streptomycin (*Science* 102:506, Nov. 16, 1945).

3. *Interestings:* J. Barcroft introduces symposium report on iodinated proteins (*J. Endocrin* 4:219-370, 1945). E. J. Carey & Co. continue studies on nerve endings, reporting traumatic shock effects (*Amer. J. Path.*, 21:935, 72 plates, 1945). E. Shorr & Co. report on vascular agents in shock (*Science* 102:489-498, Nov. 16, 1945). M. Spiegel-Adolf & Co. suggest breakdown of nuclear substances from electric convulsions (*J. Neuropath* 4:277, 1945). E. S. deLustig and E. Montnori find cardioregulatory agent in embryonic myocardium similar to that localized in nodal tissue of adult heart (*Rev. Soc. Argentina Biol.*, 12:187-201, 1945). R. N. Lyons indicates vitamine K may be functional part of thrombin molecule (*Austral. J. Exp. Biol. Med. Sci.*, 23:131, 1945). T. & J. Gillman describe liver aspiration biopsy technique (*S. Afr. J. Med. Sci.*, 10:53, 1945). A. S. Wiener offers theory and nomenclature of Hr blood factors (*Science*, 102:479, Nov. 9, 1945). J. H. Gaddum wisely discusses lognormal distributions (*Nature*, 156:463, Oct. 20, 1945). J. F. Danielli well notes E. K. Riedeal's Liversidge Lecture on biological significance of reactions at interfaces (*Ibid* 468). E. J. Conway & Co. (Dublin), offer new theory of gastric HCl formation (*Ibid* 477). G. E. Glock finds thiourea cmpds. produce adrenal cortex deficiency (*Ibid* 508, Oct. 27, 1945). Just arrived is E. A. Pequeno's remarkable auto-observation of 5 years experimental infection with treponema carateum, causing "pinto" (*An Inst. Invest. Cient Univ. Nuevo Leon, Monterrey*, 1:17-72, 1944). J. T. Chesterman and W. J. Sheehan show statistically significant effect of morphine in preventing postoperative ileus (B. M. J., *2*:528, Oct. 20, 1945). Our own E. L. Porter and A. N. Taylor discuss facilitation of flexion reflex in relation to causalgia (*J. Neurophysiol.*, 8:289, 1945) and our R. F. Blount shows interrelationship of parts of hypophysis in development (*J. Exp Zool.*, 100:79, 1945).

Plasma for Civilians.—Blood plasma—the substance that saved thousands of lives on the battlefields—soon will be available without cost to civilians who need it.

The Red Cross, announcing this on December 27, said it would distribute 1,250,000 units of plasma which had been declared surplus by the Army and Navy. This was estimated to be enough to meet civilian needs for two years.

A three months' supply will make up the initial shipment to health departments in each state. The departments, in turn, will distribute it to hospitals, health agencies and physicians.

The Red Cross announcement said:

"As envisaged under present plans, every acceptable hospital in every community will have a supply of plasma on hand, ready for instant use in the treatment of any patient without charge for the product. Every physician licensed by the State to practice medicine and surgery may also keep a small supply for emergency use."

Red Cross reserves, which will be tapped as necessary to replenish state supplies, will be stored in warehouses at New York, Alexandria, Va., Atlanta, St. Louis, and San Francisco.

In addition to the plasma for civilians, a five-year supply will be turned over to the Veterans' Administration

Red Cross officials estimated the 1,250,000 units represented approximately 2,000,000 donations.

A.M.A. Bureau of Health Education.—The American Medical Association and the National Broadcasting Company will resume network broadcasts of the dramatized health program which has been on the air consecutively for ten years.

This eleventh season the series will be entitled "Doctors at Home." It will be a serial dramatic story dealing with a fictitious but typical American doctor returned from military service to care for his patients, reëstablish his community contacts and service his people in curative and preventive medicine.

Effects of Salt in the Diet on High Blood Pressure.—A clearer understanding of high blood pressure may result from preliminary rat experiments at the University of California by Dr. David M. Greenberg, professor of biochemistry, and Elizabeth M. Cuthbertson, medical student.

The experiments clear up to a degree the understanding of the effects of salt in the diet on high blood pressure. It has been known that a diet high in salt content is deleterious in cases of high blood pressure due to kidney disease. Until now the cause for the damage has been attributed to high intake of sodium, which is combined with chlorine as sodium chloride to make table salt.

The scientists' experiments indicate the damage may be done by chloride rather than sodium.

Rats deficient in chloride were found to utilize their food inefficiently and gained less weight per unit of food. It was found that the chloride-deficient rats have an increased amount of chloride in the heart, which indicates the deficiency causes an overworking of the heart Deficiency of chloride was also shown to produce kidney damage.

The experiments were conducted with artificially radioactive elements produced in the atom-smashing cyclotron.

Journal of the History of Medicine.—The first number of the new *Journal of the History of Medicine and Allied Sciences*, to be published quarterly by Henry Schuman, will make its appearance in January.

The *Journal* makes its debut under the editorial guidance of a group of scholars in the field of medical history.

The Consulting Editors are prominent historians representing major centers of medical history throughout the United States, Canada, Latin America and Europe. The global representation of the editorial boards makes this publication the world's sole medical journal of international outlook.

A profession which still acknowledges the importance of the historical approach each time it writes or speaks of the *case history*, must also admit that sound historical knowledge of the medical past lays the foundations for better understanding of daily tasks. Besides being of practical use to the physician, the history of medicine should be an important cultural element in the training of every physician. It is an integral part of medical culture and its preservation is vital.

The policy of the *Journal* is to deal in a broad and varied manner with the field of medical history. In keeping with that policy, the Editors have invited contributions on all aspects of the history of medicine, as well as public health, dentistry, nursing, pharmacy, veterinary medicine and the various sciences that impinge on medicine.

Oregon Academy of Ophthalmology and Otolaryngology.—The Sixth Annual Spring Post Graduate Course in Ophthalmology and Otolaryngology will be held in Portland, April 15-20, 1946. Another program has been arranged by the Oregon Academy and the University of Oregon Medical School. We are particularly fortunate in having two outstanding men in their respective fields as guest speakers: Dr. Algernon B. Reese, Professor of Ophthalmology at Columbia University, New York City, and Dr. Gabriel Tucker, Professor of Bronchoscopy and Laryngology at University of Pennsylvania Graduate School, Philadelphia.

There will also be lectures, clinical demonstrations and ward rounds.

Preliminary programs will be out about February 15th and you may secure yours, and further information, from Dr. Harold M. U'ren, Secretary 624 Medical Arts Bldg., Portland 5, Oregon.

Clinic on Rheumatic Heart Disease.—A clinical demonstration of rheumatic heart disease was conducted during the week of November 22, for California physicians by members of the department of pediatrics of the Medical School of the University of California.

Dr. Peter Cohen, lecturer in pediatrics, Dr. Mary B. Olney and Dr. Alice Potter, assistant clinical professors of pediatrics, in coöperation with Dr. Helen Johnson, of the State Health Department, arranged the clinic in the University Hospital and discussed the cases from the outpatient department of the children's heart clinic of the University and the Crippled Children's division of the State Health Department.

More than 200 physicians visited the clinic, one of the aims of which was to emphasize the need for early diagnosis and prompt treatment of rheumatic fever. Patients with different phases of rheumatic heart disease were placed in separate cubicles so that the physicians could examine them. Charts, cardiograms, and chest x-rays showing the heart shadow were prepared for each, and heart beats were magnified with electronic equipment. Rheumatic fever is one of the leading causes of death in childhood and is also responsible for much adult disability, the pediatricians say.

Psychiatrists Organize to Meet National Emergency.—The two leading national organizations in the field of psychiatry have united to help meet the critical situation in which the country finds itself as a result of psychiatric problems arising out of the war. In the field of psychiatry, which has always been short of well-trained personnel, there are literally thousands of places where psychiatrists are needed. There also are thousands of medical men who had some experince in psychiatry during the war, and are now seeking training opportunities.

As an initial step in bringing the psychiatrically trained and psychiatrically minded medical men together with the opportunities, the American Psychiatric Association, the oldest specialty society in America, founded more than one hundred years ago, has joined forces with the National Committee for Mental Hygiene, the pioneer organization in the field of mental health, which was founded in 1909.

Inquiries should be addressed to Captain Forrest M. Harrison (MC) USN, National Committee for Mental Hygiene, 1790 Broadway, New York City, 19.

Reginald Knight Smith Lecture.—Mount Zion Hospital, San Francisco, is presenting its second annual Reginald Knight Smith Lecture on Thursday, January 24, 1946. This lecture is presented in memory of Dr. Reginald Knight Smith who served as Chief of the Division of Obstetrics from 1909-1937 and in recognition of his outstanding medical services to the community.

Each year a prominent speaker of national medical reputation is invited to be the guest speaker on a subject of interest to the general medical profession preferably concerned with the newer developments in medicine. This year Dr. Max Pinner has been invited to present this lecture. The subject this year is "Modern Trends in the Treatment of Pulmonary Tuberculosis." Dr. Pinner is the editor of the *American Review of Tuberculosis*. He has been chief of the division of pulmonary diseases of Montefiore Hospital, New York from 1938-1945. Dr. Pinner is an outstanding authority on the subject of tuberculosis and has published approximately one hundred papers relating to pathological, bacteriological, immuniological as well as clinical aspects of tuberculosis. He was a contributor to Alexander's "Collapse-Therapy of Tuberculosis." This year Charles C. Thomas published his book entitled, "Pulmonary Tuberculosis in the Adult." In addition to holding the title of clinical professor of medicine, College of Physicians and Surgeons Columbia University from 1939-1945, he has also held important positions at the University of Illinois, as pathologist to the Herman Keefer Hospital, Detroit, assistant director in charge of laboratories and research at the Desert Sanitarium, Tucson, Arizona, and pathologist at the New York State Tuberculosis Hospitals. He is a fellow of the American College of Physicians, New York Academy of Medicine, American Trudeau Society, American Association for Thoracic Surgery.

Thirty Topics Await Special Session of California Legislature.—Governor Earl Warren disclosed on December 27 his call for the January 7 special reconversion session of the Legislature will include at least thirty different subjects.

Eight to ten items, he said, would throw "wide open" such highly controversial subjects as specific allocation of the $90,000,000 fund for state aid to local postwar public building projects. Veterans' housing, child care centers, full employment, and legislative aid for development of private and commercial aviation also are at the top of the list.

Besides the $90,000,000 employment and construction fund, Governor Warren revealed the state's entire postwar building programs, for which an additional $145,000,000 has been earmarked, will be up for consideration at the special session.

University of California Professor Comments on Atom.—The Moscow Declaration on atomic bomb control is a "very good beginning" to international control of atomic research, Dr. J. Robert Oppenheimer, University of California professor and former director of the Los Alamos, N. M., project which assembled and tested the atomic bomb, said in Berkeley, on December 31.

"Atomic control can be handled only as an international problem," Dr. Oppenheimer said, "While international inspection of atomic search is not practical now, it may become so if all nations will agree to conduct their research openly."

In no country to which people have reasonable access would it be possible to conduct secret nuclear research, the young scientist declared. . . .

Dr. Oppenheimer now is teaching theoretical nuclear physics at California Institute of Technology and is spending the holidays in Berkeley. He plans to return to Cal Tech, where he will teach graduate students and "learn more about the nature of matter."

Mississippi Valley Medical Society 1945 Essay Contest.—The Mississippi Valley Medical Society is resuming its annual Essay Contest which has not been held during the war. In 1946 it offers a cash prize of $100.00, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents of the United States. The winner will be invited to present his contribution before the next annual meeting of the Mississippi Valley Medical Society to be held at St. Louis, Mo., September 25, 26, 27, 1946, the Society reserving the exclusive right to first publish the essay in its official publication—the *Mississippi Valley Medical Journal* (incorporating the *Radiologic Review*). All contributions shall not exceed 5,000 words, be typewritten in English in manuscript form, submitted in five copies and must be received not later than May 1, 1946.

Further details may be secured from Harold Swanberg, M.D., Secretary, Mississippi Valley Medical Society, 209-224 W. C. U. Building, Quincy, Illinois.

U. C. Dean Returns From Medical Meeting.—Most U. S. medical schools will probably abandon the present wartime accelerated program of study, said Dr. Francis S. Smyth, dean of the University of California Medical School, on his return from a recent trip in the East.

Dr. Smyth attended a meeting of the Association of Medical Colleges at Pittsburgh, Pa., which cast a solid vote against the accelerated program.

Red Cross Names Health Services Advisory Board.—Basil O'Connor, on December 3, announced appointment of an Advisory Board on Health Services to coördinate activities of the American Red Cross in the health field. Mr. O'Connor, national Red Cross chairman, named as board chairman Lewis H. Weed, M.D., of Baltimore. Dr. Weed also is chairman of the medical sciences division of the National Research Council; and director, School of Medicine, Johns Hopkins University.

The committee consists of 109 men and women from 25 states and the District of Columbia, representing every specialty in the field of health. Not only physicians were appointed, but also nurses, dentists, health educators, medical and psychiatric social workers, hospital administrators, medical publicists, nutritionists, pediatricians, public health administrators, and sanitary engineers.

Three members of the advisory board will serve as general vice chairmen. They are: Roger I. Lee, M.D., Boston, Mass., John D Lyttle, M.D., Los Angeles, Calif., and John Romano, M.D., Cincinnati, Ohio.

Mr. O'Connor said that the first meeting of the Board's executive committee will be held in Washington, December 15. The entire board will meet at least once a year.

The American College of Physicians.—The American College of Physicians will resume its annual meetings in 1946 and has now definitely chosen Philadelphia, May 13-17, inclusive. Headquarters will be at the Philadelphia Municipal Auditorium, 34th Street below Spruce. The meeting will be conducted under the presidency of Dr. Ernest E. Irons, Chicago, Illinois, and the general chairmanship of Dr. George Morris Piersol, Philadelphia, Pennsylvania.

State Psychiatry Needs Cited.—Treatment and prevention of brain disorders in California will be greatly aided by adoption of the proposed reorganization of the State Department of Institutions, says Dr. Karl M. Bowman, professor of psychiatry in the University of California Medical School and medical superintendent of the Langley Porter Clinic.

The proposed reorganization calls for an increased budget to provide for more psychiatrists, nurses, occupational therapists, physical therapists, psychiatric social workers and attendants. It also asks for the construction and setting up of four mental hygiene clinics at Los Angeles, and calls for a postwar building program. The State Legislature has already tentatively allocated $40 million for buildings.

Dr. Bowman pointed out that there is already an overcrowding in California mental disease hospitals of 17.1 per cent, and that it is estimated there will be an increase of 7,000 mentally ill and mental defectives in state institutions by 1948.

Dr. Bowman said that the reason for the increase in mentally ill probably is the result of more persons living to be 60 or more years of age, and the incidence of mental diseases is much higher in such age groups.

American Board of Ophthalmology.—Due to transportation difficulties the examination of the Board, originally scheduled for Los Angeles, January 28th to 31st has been changed to San Francisco, June 22nd to 25th, inclusive, 1946.

Mass X-Ray Program.—The California Tuberculosis and Health Association and the 61 local tuberculosis associations have pioneered in the use of the x-ray for mass case finding surveys.

The truck mounted unit of the State association travels continuously from county to county to provide free x-ray service. During the first ten months in 1945, 54,446 films were taken by this unit. Another unit lent to the association temporarily by the U. S. Public Health Association took 20,966 films during the time it was available.

Local tuberculosis associations in Alameda, San Francisco, Fresno, Santa Clara, San Mateo, Santa Cruz, Los Angeles and San Bernardino Counties have purchased their own x-ray units and have taken thousands of films during the year. Several other associations, including those in Kern, Stanislaus and Merced counties, have x-ray units on order.

The percentage of films "suspicious" of tuberculosis has varied according to the age group and the population characteristics of the various communities. In adult groups, this percentage has ranged from 2 to 5 per cent.

Surveys are conducted in coöperation with local public health departments which have the responsibility of seeing that patients receive treatment and that further spread of the disease is prevented.

Scholarships in Health Education.—Five scholarships for postgraduate study at the University of California have been granted by the State Department of Public Health to students who are taking work leading to a Master of Public Health degree with specialization in health education. Two other students are enrolled at the University of North Carolina on the same type of scholarship.

Upon completion of a year's study, the seven students will be available for employment in local health departments in California.

High Winter Incidence of Poliomyelitis in Los Angeles.—Health officer George M. Uhl in his December 29 *Bulletin*, stated:

"While the total number of cases occurring during November and December is only 53, it is the highest in the history of Los Angeles. A high winter poliomyelitis incidence usually represents either a hangover from a previous summer epidemic or the start of a coming epidemic. Coming after a low summer incidence, the present relatively large number of cases points toward the start of an epidemic which may flare up during next summer. This possibility becomes especially significant when we consider that for the first time in the history of the city there were more cases reported in November than in October.

"While it is difficult to prognosticate, because of absence of regular cycles, nevertheless we should be prepared for an outbreak of poliomyelitis during the coming summer."

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

How Many Californians? It Looks Like 9,250,000

California's population by the first of the year will be 9,250,000, an increase approximately 34 per cent over 1940, according to an estimate by the California Taxpayers' Association released on December 18 through the Associated Press. The State's population was given as 6,907,387 in the 1940 census.

San Francisco's population as shown in the special Federal census taken in August was 827,400, a gain of more than 200,000 over the number of permanent residents shown by the 1940 Federal census.

The Association's estimate for Los Angeles County is 3,584,000 compared with 2,785,643 shown by Federal census in 1940, an increase of 798,400 or 29 per cent.

The Association based its figures primarily on elementary school enrollment, employment records and ration book rolls.—San Francisco *Chronicle*, December 8.

Population in Los Angeles County of 3,456,277 by Jan. 1 (Estimated)

On next January 1, Los Angeles County will have a total population of 3,456,277 housed in 1,134,828 dwelling units, according to figures released on December 9, by the housing division of the County Regional Planning Commission.

The estimated population figures for the entire county represents an increase of 670,584 since April, 1940. Dwelling units during the same period have increased 173,287, according to the report.

The city of Los Angeles, on January 1, will have an estimated population of 1,769,659, an increase of 265,374 since 1940, the report asserts. . . .—Los Angeles *Times*, December 9.

Send the Doctors Home

The Army points with just pride to its conquest over disease during World War II. Its disease death rate dropped from 14.1 to 0.6 per 1,000, compared with World War I. Employing penicillin, sulfonamides, DDT, vaccines, blood and plasma, the Army medical men pinned down such enemies as yellow fever, dysentery, typhus, tetanus, pneumonia and meningitis.

Understandably, the Army glories in its doctors. But grateful fondness must not turn into fond foolishness. It's time to demobolize the physicians so they may pursue the common foe on the civilian field.—Editorial in San Francisco *News*, December 31.

A Year of Medical Discovery

Reviewing the year's scientific progress, Dr. Robert C. Miller, director of the California Academy of Science, recently stated that while 1945 unquestionably would be known as the "year of the atomic bomb," the advances in treatment and prevention of diseases ranged foremost in terms of benefit to humanity.

The little-publicized discovery of promin — a distant relative of the sulfa group—will enable hundreds of lepers to thank 1945 scientists for improved treatment of their disease, he said.

"The year will be remembered as the year in which a cure was found for cholera that has been killing hundreds of thousands annually," he said.

Dr. Miller listed two other standout discoveries:

1. Bal, a new remedy for arsenic poisoning.
2. DDT, one of the most effective agents ever developed to combat typhus, malaria and sleeping sickness plagues.

"The great scientific events of this year are almost entirely due to the mobilization of research work for military purposes," Dr. Miller said.

Bal was the result of research to find an antidote for the effects of the deadly poison gas, lewisite, he said. The cholera cure evolved from U. S. medical officers' experiments involving blood plasma and drugs, he said. The cure was 100 per cent effective.

Other important advances listed by the academy were:

1. Aerial and strip mapping.
2. The return to prominence of mathematics, "by-passed before the war" but now restored by military needs to its rightful place.
3. Nutritional gains through study by the U. S. Quartermaster Corps designed to maintain the best-fed Army in the world.

Output Speeded of "Carbon 13," New Wonder Element Ranked in Importance With X-Ray

Philadelphia, Jan. 1.—(AP.)—Expanded production of Carbon 13, which recent experiments in biochemical research indicate "gives promise of ranking in importance with x-ray as a tool of medical science," was announced here today by Sun Oil Company, and Houdry Process Corporation.

The isotope, so rare that current production has been at the rate of less than one-half ounce per year, "may be compared to a chemical microscope that makes it possible for the chemist to see and follow chemical reactions in the body not possible with the x-ray," a joint statement declared.

Carbon 13 has been described as appearing like an ordinary carbon. It can be used to produce any of the compounds normally composed of carbon, such as sugar, alcohol, the hydrocarbons of gasoline and thousands of others, including synthetic rubber. Or, the statement continued, Carbon 13 can be used to grow vegetables which have some or all carbon atoms with atomic mass equaling 13. These compounds and vegetables, injected into or eaten by living organisms, including humans, contain the necessary "tracers" by which their effect on body functions can be discovered.

Research with the isotope, the companies said, already has led to discovery of how fats are broken down in the animal organism to create energy necessary to carry on the life process. In contradiction of a long established theory, Dr. C. H. Werkman of Iowa State College and Dr. E. A. Evans of the University of Chicago reported after experiments with Carbon 13 that animals as well as plants utilize carbon dioxide.

"The possibilities of research with Carbon 13 are almost beyond imagination," the statement said. "It is a new and powerful tool for a revolutionary approach to studies of the fundamental processes that occur in all living things, as well as metabolic disease processes such as cancer, diabetes, hardening of the arteries, so-called 'heart trouble' and others."

The companies announced plans for construction, by Sun Oil, of two plants to produce "comparatively substantial quantities of Carbon 13." Houdry now has in operation, at Marcus Hook, Pa., a thermal diffusion plant producing about one-fourth gram of Carbon 13 per month and has made this available without cost to members of the isotope research committee.

Present cost of Carbon 13 is approximately $400 per gram, the statement said, adding that the new plants should reduce this to approximately $40.—San Francisco *Examiner*, January 2.

American Medical Association Backs Voluntary Prepaid Plans

Chicago, Dec. 5.—(AP.)—The American Medical Association gave the green light today to a program designed to establish a nationwide network of "voluntary" prepayment medical plans, to be sponsored by medical societies.

The Association, through its House of Delegates, took action after branding as "socialized medicine" a proposal by President Truman for a Federal system of sickness insurance.

The Association's board of trustees and its council on medical service and public relations were instructed "to proceed as promptly as possible with the development of a specific national health program, with emphasis upon the nationwide organization of locally administered prepayment medical plans sponsored by the medical societies."

"This is the go-ahead signal we've been awaiting for a long time," said Dr. Edward J. McCormick of Toledo, Ohio, chairman of the council.

"The A.M.A. for several years has sponsored extensive studies of existing pre-payment plans and has favored the extension of these as much as possible, but we now have an actual directive to promote the establishment of voluntary plans to cover the whole nation."

Declaring that 47 voluntary plans—sponsored by physicians—now are in operation in 24 states and that almost every other state medical society is in the process of developing plans, McCormick said:

"Up to now the states haven't had much to guide them. But, from our studies of existing plans, we will make our first objective the development of a 'skeleton plan' for the guidance of communities now uncovered."

McCormick and other members of his council gave this version of their program:

1. All existing plans and those that may be developed in other areas will maintain local autonomy, but an attempt will be made to coördinate their activities on some common basis so that a subscriber to a plan in Ohio would be able to get medical care in Indiana if he got sick in the latter state.

"Blue Cross" Plan

"We hope to get things on such a basis," said Thomas A. Hendricks of Indianapolis, layman executive officer of the council, "that a man can carry a medical service card with him anywhere in the country and get the same service he would in his own home town."

2. Whereas some existing plans are indemnity systems (straight cash at time of sickness) and others are medical service plans (with the plan paying the doctor's bill), Dr. McCormick said the A.M.A. would "very likely" suggest the latter type in new areas.

"Medical care insurance," he said, "might be sold in all probability with hospital coverage programs—such as the Blue Cross."

"We now have enough actual experience from our studies of prepayment plans that we're certain that this type of medical and surgical coverage can be given at less than half the cost that any government plan would entail," McCormick added.—San Francisco *Chronicle*, December 6.

Doctors Will Seek to Sell Medical Care Plan to Nation

Chicago, Dec. 6.—(AP.)—The American Medical Association is committed to a task of super salesmanship—encouraging close to 100,000,000 people throughout the nation to subscribe to "voluntary prepaid medical care" plans.

The Association's policy making group—the House of Delegates—headed homeward after a three day meeting which was highlighted by this development late yesterday.

Gives Go Ahead Signal

The House gave the go ahead signal to a program designed to establish the nationwide system of "voluntary" prepayment medical plans to be sponsored by medical societies.

To the Association's board of trustees and council on medical service and public relations is assigned the job of proceeding "as promptly as possible with the development of a specific national health program, with emphasis upon the nationwide organization of locally administered prepayment medical plans sponsored by the medical societies."

Those two groups will aim at promoting the development of medical care plans in large areas of the country now uncovered and will seek to coördinate such plans and also plans already in operation, in such a way that a subscriber in any part of the country will be able to have his doctor's bill paid no matter where he traveled.

23,000,000 Covered

Dr. Morris Fishbein, editor of the *Journal of the A.M.A.*, said 23,000,000 persons already are covered by private insurance company plans for industrial workers. He said also 5,000,000 persons are covered by 47 physicians' sponsored plans in 24 states, but that an undetermined number of the 5,000,000 are included in the 23,000,000. The overlapse occurred, he said, because some people seek additional coverage features from various plans.

Even with that head start, some delegates said the task of organization of plans for the rest of the nation cannot be accomplished "overnight."

San Francisco Is Selected

The House of Delegates selected San Francisco for the 1946 general convention of the A.M.A. next July. Dr. Harrison H. Shoulders, Nashville, Tenn., was chosen president-elect. Dr. William R. Molony, Los Angeles, was elected vice-president. Dr. John H. Fitzgibbon, Portland, Ore., was elected to a five-year term on the A.M.A. Board of Trustees, and Dr. Dwight H. Murray, Napa, Calif., was elected to serve on the Board until 1947.—Sacramento *Bee*, December 6.

The Battle of the Bugs

What We Did About Biological Warfare

Washington, Jan. 3.—(UP.)—Some of the more important accomplishments of the American biological warfare program revealed today were:

1. Development of methods and facilities for mass production of microörganisms and their products.

2. Development of methods for the rapid and accurate detection of minute quantities of disease-producing agents.

3. Significant contributions on the control of airborne agents.

4. Production and isolation for the first time of a crystalline bacterial toxin, which has opened the way for the preparation of a more highly purified immunizing toxoid.

5. Development of an effective toxoid in sufficient quantities to protect large scale operations should this be necessary.

6. Significant contributions to knowledge concerning the development of immunity in human beings and animals against infectious diseases.

7. Important advances in the treatment of certain infectious diseases of human beings and animals and in the development of effective protective clothing and equipment.

8. Development of laboratory animal propagation and maintenance facilities to supply the tremendous number of approved strains of experimental animals required for investigations.

9. Applications of special photographic techniques to the study of airborne microörganisms and the safety of laboratory procedure.

10. Information on the effects of more than 1,000 different chemical agents on living plants.

11. Studies of the production and control of certain diseases of plants.—San Francisco *Chronicle*, January 4.

"Better Than Atabrine or Quinine"

New Drug Is Found for Malaria Cases

Washington, Jan. 3.—(AP.)—American scientists reported today development of a new synthetic drug called superior to atabrine or quinine for malaria.

Termed "SN 7618," it relieves acute attacks of the disease three times faster than the other two drugs, according to the Board for the Coördination of Malarial studies.

In addition, the board said, it can be taken weekly instead of daily to keep the disease in a mild state, doesn't stain the skin as does atabrine, doesn't cause buzzing in the ears as does quinine, and doesn't make the patient sick at his stomach as the other two drugs sometimes do.

At the same time the scientists disclosed another new drug was offering "definite promise" of being the long-sought actual cure for the relapsing form of malaria—the type with which many returning servicemen are afflicted. They did not identify the drug specifically.

Neither drug is available to the public yet. The latter of the two is still in an experimental stage.

Conscientious objectors and prison inmates participated as volunteer "human guinea pigs," and several hundred thousand canary birds, ducks, chickens, monkeys, dogs, rabbits and mice were used in laboratory tests.

The first drug has been employed successfully in 5,000 human cases of malaria, the scientists said, but they would not recommend its release to civilians generally until still further trials are made.

"SN 7618" was described by the board as superior to atabrine for these reasons:

1. It relieves acute attacks of malaria in one to two days, compared with four to six for atabrine.

2. It need be taken only once a week instead of daily. And the once-a-week dosage is less than half the total amount of atabrine that must be consumed in a week.

3. It doesn't stain the skin.

4. It doesn't produce disagreeable stomach ailments.

5. It can be produced at the same cost as atabrine.

(Since atabrine was rated superior by the same group to quinine more than a year ago, they therefore class the new drug superior to both.)—San Francisco *Chronicle*, January 4.

A Warning to the Legislature

Conference Ends With Reminder to Lawmakers: This Is An Election Year

Sacramento, Jan. 6.—Notice was served on the Legislature on January 6, that representatives of the week-end gathering of the "state-wide emergency legislative conference" shall "be constantly at hand during the coming deliberations to remind our elected representatives that 1946 is here, and November (election time) is not too far away."

The notice was served by Democratic Attorney General

Robert W. Kenny in his final summation address detailing the work of the week-end conference panels. The conference was sponsored by a C.I.O. Political Action Committee-Democratic coalition although it was described as a "nonpartisan meeting" by Assemblyman Albert Dekker.

Dekker touched off a demonstration for the Attorney General by addressing him as "Governor." Most of the delegates informally declared their hope to "draft" Kenny as a candidate against Governor Warren.

Kenny himself wanted to keep the gubernatorial talk out of the conference lest it undo the work of the week-end. . . .

Two items not on the call for the special session received attention of the unemployment insurance and social security panel. One recommended a $60 old age pension at 60 and a $60 minimum for aid to blind persons. Another was approval of compulsory health and hospital insurance. . . .—San Francisco *Chronicle,* January 6.

Germ War Research at University of California

War with bacteria and other microörganisms instead of bullets. . . .

War with plagues that would not be known to be war until millions were stricken. . . .

War, whose preparations by a handful of men could be disguised as the natural peacetime trends of medical research. . . .

The War and Navy Departments on January 4, lifted, ever so slightly, the curtain of secrecy around wartime researches, proving that this nightmare is a definite possibility.

Simultaneous statements disclosed the United States, through investigations that centered at the University of California at Berkeley, mastered this new art of killing under threats that Germany and Japan would first use the tricks of biological warfare.

Japan, the War Department said, had made "definite progress" in preparing for bacterial warfare, but the war ended before she could develop the weapon for effective use.

Allies Were Ahead

The Allies, however, were far ahead of the Axis in the field, the services added. They did not intend to use germ warfare unless the enemy did first.

Navy research conducted over a 33-month period, primarily at the Berkeley campus, where students and staff thought something else was under analysis, confirmed that man-made epidemics could be an effective weapon in future wars.

The Navy said its "top secret" research resulted in information of "great value" in protecting the United States against possible bacterial attacks, and would contribute to peacetime control of communicable, airborne diseases.

Captain Albert Paul Krueger, Medical Corps, U.S.N.R., professor of bacteriology at U. C., commanded the U. C. project which was commissioned prior to Dec. 7, 1941, under direction of the then surgeon general of the Navy, Vice Admiral Ross T. McIntire.

The staff consisted of 19 officers and 45 enlisted men on V-J Day.

War Department researches were carried on additionally at laboratories in Maryland, Mississipi, Utah and Indiana. A total of 4,000 scientists and assistant personnel were employed by both services in inquiries labeled top secret.

"Influenza Research"

Dr. Krueger's work into bacterial war possibilities, it can now be told, had a public blind—that the microbe hunters were winning a hard fight against influenza viruses.

While a token group did evolve some preventatives and measures against the wracking flu bugs, the greater experiments went on, apparently to the point where the Navy could spread chaos with a disease described as "centuries old and one of the greatest killers."

The Navy will not disclose the disease with which it conducted its research at U. C., but levelers falling into that general description might mean cholera, bubonic plague or typhus.

A protective suit with self contained oxygen supply was devised for the use of workers in any prospective rescue or decontamination operation.

The unit also participated in the testing of special anti-bacterial masks, vaccines, antibiotics and sulfa drugs—the measures designed for mass protections.

"No Infections Arose"

So efficient were precautionary measures taken by and for project workers that no infection due to the organisms studied occurred among investigators, the Navy reported.

The work of the Berkeley unit is continuing into 1946 coördinated by the Bureau of Medicine and Surgery with the Army-Navy biological welfare program.

The War Department report, made to the secretary of war by George W. Merck, special consultant, declared the biological warfare program was undertaken "under the goad of necessity and aimed primarily toward securing for this nation and its troops in the field adequate protection against the possible use of biological warfare by the enemy."

MEDICAL JURISPRUDENCE†

Hartley F. Peart, Esq.
San Francisco

Contracts for the Maintenance of a Physician's Practice While He is in Military Service

The case of *Hamilton vs. Salopek,* 71 ACA 107, decided October 1, 1945, by the District Court of Appeal, involved construction of a contract between two physicians under which the defendant had agreed to maintain the practice of the plaintiff while the plaintiff was absent in military service.

The issue involved in the case was the right of the plaintiff, after his return from military service, to share in the accounts receivable which had accrued during the course of the defendant's operation of the office. The contract provided that the defendant was placed in charge of the plaintiff's medical office and professional equipment while the latter was away in service. Under the terms of the contract, defendant was to receive a specified salary or drawing account and a "designated percentage of the net office income." The contract provided that the defendant "does by these presents agree to associate with and maintain the medical practice of the party of the first part (plaintiff) until the party of the first part shall be released from the Government service and resume his said practice." The last paragraph of the contract specifically provided: "The purpose of this agreement is to provide for such period of time as the party of the first part is in the military service of the United States and absent from the community, and for the preservation of his practice."

During the time plaintiff was in service the defendant regularly accounted for and paid to plaintiff his share of the cash receipts, but upon the plaintiff's return and resumption of his practice a dispute arose as to plaintiff's rights to any portion of the outstanding accounts receivable, and plaintiff brought this action to recover his share.

The court's decision was as follows:

"From this summary of the entire agreement it appears that said contract was nothing more than a contract of employment wherein a profit-sharing arrangement had been worked out between the parties. Nothing can be found therein even intimating that Dr. A was in any way selling or disposing of, or otherwise turning over his practice to Dr. B. The practice remained that of Dr. A for the preservation of which the contract was executed. This being true, the defendant was entitled only to that 'compensation' which the contract specifically gave to him. Under the circumstances herein plaintiff might well have been entitled to an accounting of all accounts receivable from the defendant. However, plaintiff by his complaint merely requested that defendant be required to account for plaintiff's share in the accounts receivable on the same basis as provided in the agreement for the division of 'net office income.'

"The judgment is affirmed."

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† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIX, No. 1, January, 1921

EXCERPTS FROM EDITORIAL NOTES

Tithes [*In 1921*].—"Render unto Caesar," etc. From time to time it is advisable to publish some of the essential requirements of membership in the State Medical Society.

In the first place, it is necessary to be a licentiate in the State of California.

An officer in the Army or Navy cannot join the State Society unless he has a state license from the Board of Medical Examiners. He may become an honorary member of a County Society. This gives him no standing in the state organization.

A fellow of the American Medical Association, or a member of another State Society cannot transfer into our State Society. He must enter as a member of a county unit, and pay his full dues. Our dues are more and give more in return than others do.

Every member must be licensed by the State Board of Medical Examiners.

A member in good standing can join the Indemnity Defense Fund by paying $30. This is no yearly assessment, but periodic, probably lasting four or five years.

The physician must pay many dues and taxes to maintain his proper relation to the federal, state and municipal governments.

You must pay your narcotic tax and your municipal license, as a matter of course. If you fail in doing this, the government in question will look into your case.

But if you fail to pay your state tax, a sum of two dollars which goes to the State Board of Medical Examiners, you forfeit your license to practice medicine.

To be in good standing in the State Medical Society, to receive Medical Defense, to be a member of the fund, you must pay your state tax and your county dues.

Don't forget this! Do it now!

$100,000 to Fight Vivisection.—During the recent campaign many people wondered who was paying for the tons of lurid literature that were scattered broadcast throughout the State of California. It was evident to all that the anti-vivisectionists had abundant funds and did not hesitate to spend them. They are now preparing for their next campaign and $100,000 has just been left by the will of Ruth C. Hawkins 'to abate the wicked horror of vivisection." . . .

It is regrettable that a few prejudiced people filled with reckless emotionalism, who close their eyes and ears but unloose their tongues, can stir up so much clamor against an agency of human progress that is constantly bestowing benefits on all. They resist all rational appeal and chatter about science and logic.

A few years ago Dr. W. W. Keen wrote a convincing article on vivisection in the Ladies' Home Journal. Instead of convincing the "tender-hearted" anti-vivisec-

(Continued in Front Advertising Section, on Page 17)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M.D.

Secretary-Treasurer

Board Proceedings

At the annual meeting of the Board of Medical Examiners, held in Sacramento, October 15 to 18, 1945, the following officers were elected for the ensuing year:

Frank W. Otto, M.D., Los Angeles, President;
Herbert S. Chapman, M.D., Stockton, Vice President;
Frederick N. Scatena, M.D., Sacramento, Secretary-Treasurer.

The next regular meeting of the Board of Medical Examiners will be held in Los Angeles March 11th to 14th. At this meeting hearings will be held on petitions for restoration of licenses, as well as disciplinary proceedings against those charged with unprofessional conduct under the Business and Professions Code. Written examinations for all classes of licentiates under jurisdiction of the Board of Medical Examiners will be held at this meeting.

Applicants required to take the oral examination are requested not to appear at an examination until definitely advised to appear. The Board is handling such applicants as expeditiously as possible but must ask that they await official notice from the Board for such appearance.

News

"Dr. Rudolf von Urban, Vienna's gift to Monterey County in the division of marital relations today resigned his new job as deputy probation officer in favor of free speech, particularly as it pertains to sex. The good gray doctor announced both his decision and irritation in a 750-word letter to County Probation Officer John Kelly, after having been informed, both directly and indirectly, that he should give up service club speeches. Sworn in as probation office deputy two weeks ago, Dr. von Urban was to have taken office November 25. He agreed at that time to curtail his frank discussions on the subject of sex education before luncheon clubs, but balked when his bosses insisted he give up a speaking engagement before a State convention. . . ." (Press dispatch from Salinas, Oct. 23, published San Francisco *Chronicle*, Oct. 24, 1945.)

"Deputy District Attorney A. B. Nathanson yesterday refused to issue a manslaughter complaint against Raymond V. Fraher, accused by state medical authorities of causing the death of a three-month-old boy by posing as a physician. Nathanson said there was no evidence to support the claim that three-months-old David McInnes died last Saturday because Fraher had diagnosed his ailment wrongly and had prescribed a too-harsh remedy. The boy's parents did not follow the suggestions made by Fraher, Nathanson said. Fraher, however, was named in a misdemeanor complaint issued by Lewis C. Teegarden, Chief Complaint Deputy of the City Attorney's Office, and will be prosecuted on a violation of the medical practices code, Chief Investigator Walter N. Anderson of

(Continued in Back Advertising Section, on Page 40)

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† This column, compiled by the undersigned, strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

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The constipation frequently encountered during pregnancy, due to pressure of the fetus on the pelvic bowel, lack of exercise, and restricted diet, is alleviated by Metamucil.

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TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 30)

its free margin. The quadrate lobe extends lowest about 2 cm. to the right of the midline; a longitudinal incision 5 cm. in length, located 2 cm. to the right of the midline and above the free margin of the quadrate lobe, gives ample room for the muscle-splitting procedure. This incision may be completed while the child is straining without any hollow viscera or omentum escaping; the liver moves with respiration and bulges slightly into the wound if the abdominal muscles tighten. This incision is particularly useful when operating under local anesthesia. . . .

From an Article on "Vesico-Intestinal Fistula," by Louis Clive Jacobs, M.D., San Francisco.—Because of the rarity of this condition, I am taking the liberty of reporting a case. An elderly man, 76 years of age, a grandfather of healthy children, had been in the best of physical condition for the past 20 years. For the last three years he had had a yearly physical examination by the doctor of his life insurance company. He states that all physical findings were negative. The urine had been free from pus and albumen. He denies all venereal diseases, has never had typhoid fever. He gives a history of having suffered from gout, principally in his big toes and of a persistent psoriasis for a number of years. He has had no dysentery nor any trouble wtih his bowels or rectum. . . .

From an Article on "The Significance of Spinal Defects and Pain Occurring in Relation to Ocular Disease," by Lloyd Mills, M.D., Los Angeles.—The loss of active

(Continued on Page 36)

D*octor*—Judge

PHILIP MORRIS suggests *you* judge . . . from the evidence of your own *personal* observations . . . the value of PHILIP MORRIS Cigarettes to your patients with sensitive throats.

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154.*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60.

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Gerald L. Crenshaw, M.D., Oakland
Ina Gourley, M.D., Oakland

TWENTY-FIVE YEARS AGO

(Continued from Page 34)

interest in any possible relations between the eyes and the structures of the neck, followed the meteoric vogue of operations upon the cervical sympathetic ganglia, in a manner comparable to the operative blight which succeeded the period of complete tenotomies for strabismus.

Many clearly established facts and daily clinical observations attest, however, the continuous activity and importance of the oculo-cervical relations. As early as 1727, according to de Schweinitz, Pourfour de Petit observed that the eye became softer after section of the cervical sympathetic. Verification of this fact led to the belief that "primary disease of the cervical sympathetic ganglia might be the basal cause of glaucoma." The pressure of cervical tumors, of mediastinal polyadenitis, and fracture-dislocations of the cervical vertebrae, notably of military origin, gave further striking evidence of the effects of deviation of normal sympathetic control over the eyes. . . .

From an Article on "Etiology of 150 Cases of Bronchial Asthma," by George Piness, M.D., Los Angeles, Calif.—The growing interest that has manifested itself in the past five years in the study of the treatment and etiology of bronchial asthma, has prompted the writer to give you this study and personal observations of 150 cases of bronchial asthma. The purpose of this present work has been to determine the etiological factors in the cases above mentioned and form the basis of this report.

The patients studied were studied at the clinics of the Los Angeles County Hospital, Kaspar Cohn Hospital and in the writer's private practice. Careful physical examinations were made of each patient to rule out any organic

(Continued on Page 40)

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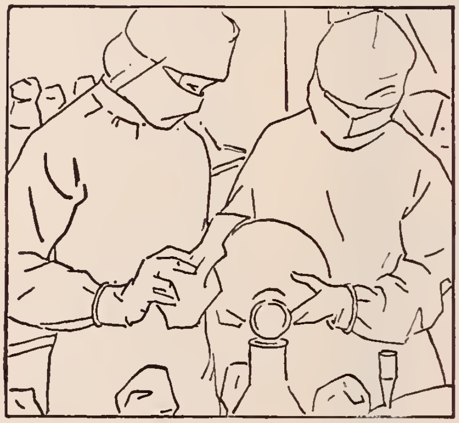

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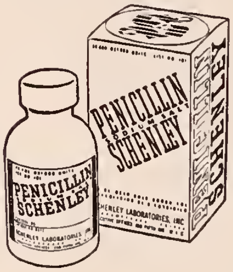

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Dietary Protein after Surgery and Other Trauma

apparently must be maintained at a level above normal in order to assure proper wound healing*and at least average resistance against infection.** The feeding of meat, therefore, in adequate amounts, as soon as it can be instituted, appears doubly advantageous: the protein content of meat is high and of highest biologic value; the human digestive tract appears well adapted for handling meat protein.**

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*" . . . in a variety of medical and surgical conditions there may occur a considerable depletion of body protein owing to a combination of factors, of which the two most important are a generally diminished protein intake and an enhanced protein catabolism. This situation inhibits wound healing, renders the liver more liable to toxic damage, impedes the regeneration of hemoglobin, prevents the resumption of normal gastrointestinal activity and delays the full return of muscular strength. It is obvious that to meet the situation an adequate supply of proteins and calories must be made available to the body. . . . This implies at least 150 Gm. of protein and 3500 calories, with as much as 500 Gm. of protein daily when trauma has been severe, as in serious burns." (HOFF, H. E.: Physiology, New England J. of Med. 231:492 [Oct. 5] 1944.)

**"Cannon . . . cites the evidence which indicates that diminished protein intake lowers resistance to infectious disease, and corroborates it by his own experiments . . . it seems probable that the small intestine is better adapted for handling protein (especially meat protein) than for other types of food. . . .it is especially well supplied with enzymes which attack protein, and the digestion of meat has been shown to be more complete than that of foods of vegetable origins." (CRANDALL, L. A., Jr.: The Clinical Significance of the Plasma Proteins, Memphis M.J. XIX:147 [Oct.] 1944.)

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TWENTY-FIVE YEARS AGO

(Continued from Page 36)

reason that might exist in the heart, lung, nose, throat, and accessory sinuses before they were subjected to the skin tests. . . .

From an Article on "A Study of Nasal Conditions in Bronchial Asthma," by Simon Jesberg, M.D., Los Angeles.—It is perhaps well to clearly define the type of asthma under discussion, as the term asthma is so often loosely applied to various conditions causing dyspnea that even today confusion sometimes exists as to the exact condition meant.

By bronchial asthma, or spasmodic asthma, is meant a condition in which there are paroxysmal attacks of dyspnea occurring at more or less irregular intervals in certain individuals, during which the alveoli of the lungs are over-distended with air due to obstruction of the smaller bronchioles. There is marked expiratory difficulty, inspiration is short and expiration much prolonged with loud piping rales. . . .

Excerpts from County Societies: Los Angeles County Medical Meeting.—November 4 at 8 p.m. in the Friday Morning Clubrooms, the regular monthly meeting was opened by the president, Dr. Rea Smith. . . .

Regular Scientific Meeting of November 18.—The Los Angeles County Medical Association met at the usual time and place. . . .

Dr. Cole spoke in high terms of Dr. G. Frank Lydston, mentioning that he was a native Californian and the first interested in gland implantation. . . .

Dr. Lydston replied that he felt like the prodigal son having returned to his old home. He thought we were all familiar with gland implantation and the elixir of life.

The limitation of material was one of the difficulties. It was found that no gland from a subject after an injury should be used for this work. By the eighth day new circulation was established and certain hormone effects noticed. The periphery received blood supply, the interior broke down and the hormones produced physiological effects. The result was a matter of nutrition, a hormone effect of stimulation. The inference was that the effect of the implanted gland was not due only to the hormone but also to other endocrine organs. Among the endocrine organs the sex gland is the most important. There is no reason then why the sex gland should not improve the function and make youth. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 62)

the State Board of Medical Examiners, said." (Los Angeles *Examiner,* Oct. 20, 1945.)

"Judge Charles R. Dyer today fined Dr. Philip V. Abrams $200 and suspended a 30 day sentence on the doctor, found guilty of falsifying a birth certificate and aiding the 'sale' of an illegitimate baby to a childless couple. Dr. Abrams was charged with altering a birth certificate for the daughter of 20-year-old Jean Ess, to read 'Diane Gay Miller, daughter of John Frances and Mrs. Jodelle Miller.' The Millers were reported to have paid $600 for the baby, $300 to Dr. Abrams, $200 to the nurse in whose home the baby was born and $100 to Miss Ess. Miss Ess, since married to Sergeant Lon Wickham, Victorville, Calif., has indicated she does not want to take the baby from the Millers. Judge Dyer said it was up

(Continued on Page 44)

In the City of Bagdad lived Hakeem, the Wise One, and many people went to him for counsel, which he gave freely to all, asking nothing in return.

There came to him a young man, who had spent much but got little, and said: "Tell me, Wise One, what shall I do to receive the most for that which I spend?"

Hakeem answered: "A thing that is bought or sold has no value unless it contains that which cannot be bought or sold. Look for the Priceless Ingredient."

"But what is this Priceless Ingredient?" asked the young man.

Spoke then the Wise One: "My son, the Priceless Ingredient of every product in the marketplace is the Honor and Integrity of him who makes it. Consider his name before you buy."

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1946

ARMOR AND ARMAMENTARIUM

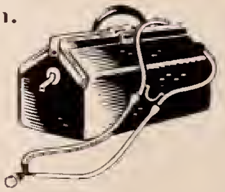
Guns are silent and grass grows in the foxholes, but there can be no peace treaty in the endless war on mankind's immortal enemy—Disease. Home comes the physician from his lifesaving on the battlefields of man-made death abroad to march again beside his colleagues who have so valiantly held the casemates of health at home.

Battle front and home front, boulevard and dirt road, the mighty facilities of the medical center and the challenge of practice in the lonely farmhouse—all are the front line trenches in humanity's continuing crusade to tame cannibal protoplasm. There is no discharge in that war.

The first cry of pain in the world was the first call for a physician. It has been answered as it echoed down the centuries; it will be answered in the unrolling years of the future.

As this questioning year of 1946 opens with the world convalescing from malignant political disease, we would like to claim the privilege of welcoming the thousands of physicians returning from unparalleled service on war fronts—of saluting those who shouldered such heavy burdens at home—of expressing the confidence that the traditional unity of the profession armed with new and potent weapons will drive the front lines of the war on disease ever forward.

We know that we are joined in this expression by all organizations which seek to play their roles, large and humble, as institutions of supply to those "bound by the covenant and oath, according to the law of medicine." S. H. Camp and Company, Jackson, Mich.



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BOARD OF MEDICAL EXAMINERS

(Continued from Page 40)

to Abrams to petition the superior court to correct his statements on the birth certificate." (Modesto *Bee*, Oct. 30, 1945, from Glendale Press dispatch, dated Oct. 30, 1945.)

"Mrs. Wilsie Harmon, 38, of 1849 Fillmore St. was critically wounded late yesterday when one of three shots fired in a scuffle between Dr. Emil Bachrach and one of two gunmen attempting to hold up his office at 1325 Octavia St. struck her in the left breast. One of the robbers was forcing nurse Lillian Otten, 35, of 990 Fulton St. into a back reception room, when Dr. Bachrach appeared and attempted to grab the robber's revolver. Two of the shots fired at the doctor lodged in the wall; the third went wild and hit Mrs. Harmon, a patient, who was taken to Central Emergency Hospital. Both gunmen escaped in the confusion. . . ." (San Francisco *News*, Nov. 3, 1945.)

"A handful of dime-store notebooks, penciled with names, dates and money paid, promises to blow the lid off San Francisco in the notorious Inez Burns abortion case. District Attorney Edmund Brown said yesterday the names of a number of prominent San Francisco women appear among the several thousand found in this secret bookkeeping system. Raiding Officers Frank Ahearn and Asssitant District Attorney Andrew J. Eyman seized the notebooks when they arrested 57-year-old Inez Brown Burns September 26. 'This case is going further than anybody thinks,' said Brown. The raided 'establishment' is the antiseptic, surgically-equipped flat

(Continued on Page 48)

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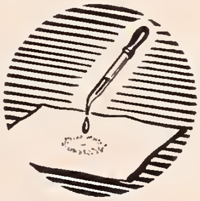

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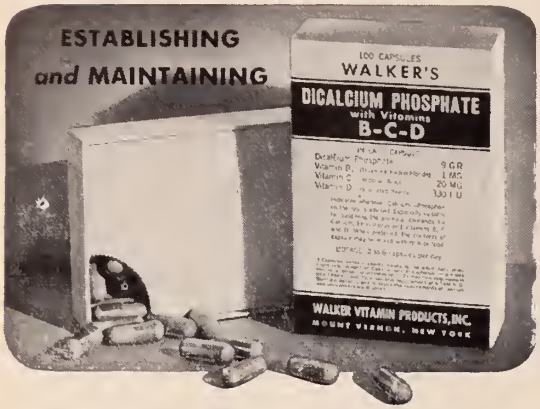

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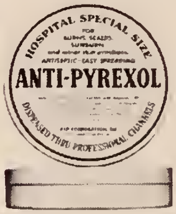

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(Continued from Page 44)

at 327 Fillmore Street, when Mrs. Inez Burns, alias Inez Brown, alias Amy Dutch, had her business. . . ." (San Francisco *Chronicle*, Nov. 8, 1945.)

"Thousands of experiments involving volunteer 'human guinea pigs,' including a 112-hour 'insomniathon' last July, were successful in minimizing sleeplessness and seasickness of combat troops, the California Institute of Technology disclosed here. Dr. David B. Tyler, professor of physiology, who directed the tests, said military censorship still prevented disclosure of the techniques by which scientists were able to keep soldiers awake through long periods of combat. . . ." (San Francisco *News*, Oct. 29, 1945, from press dispatch dated Pasadena, Oct. 29, 1945.)

Psychiatric Treatment of Promiscuous Girls

An Experimental Study

An experiment in the Psychiatric Treatment of Promiscuous Girls. The psychiatric study here referred to was made under the auspices of the Venereal Disease Division of the United States Public Health Service, the California State Department of Public Health, and the San Francisco Department of Public Health, January, Hazel G. Corrigan and Katherine P. Bradway.

A demonstration of the application of psychotherapy and psychiatric case work as a preventive measure in venereal disease control was undertaken by the Psychiatric Service of the San Francisco City Clinic. This

(Continued on Page 52)

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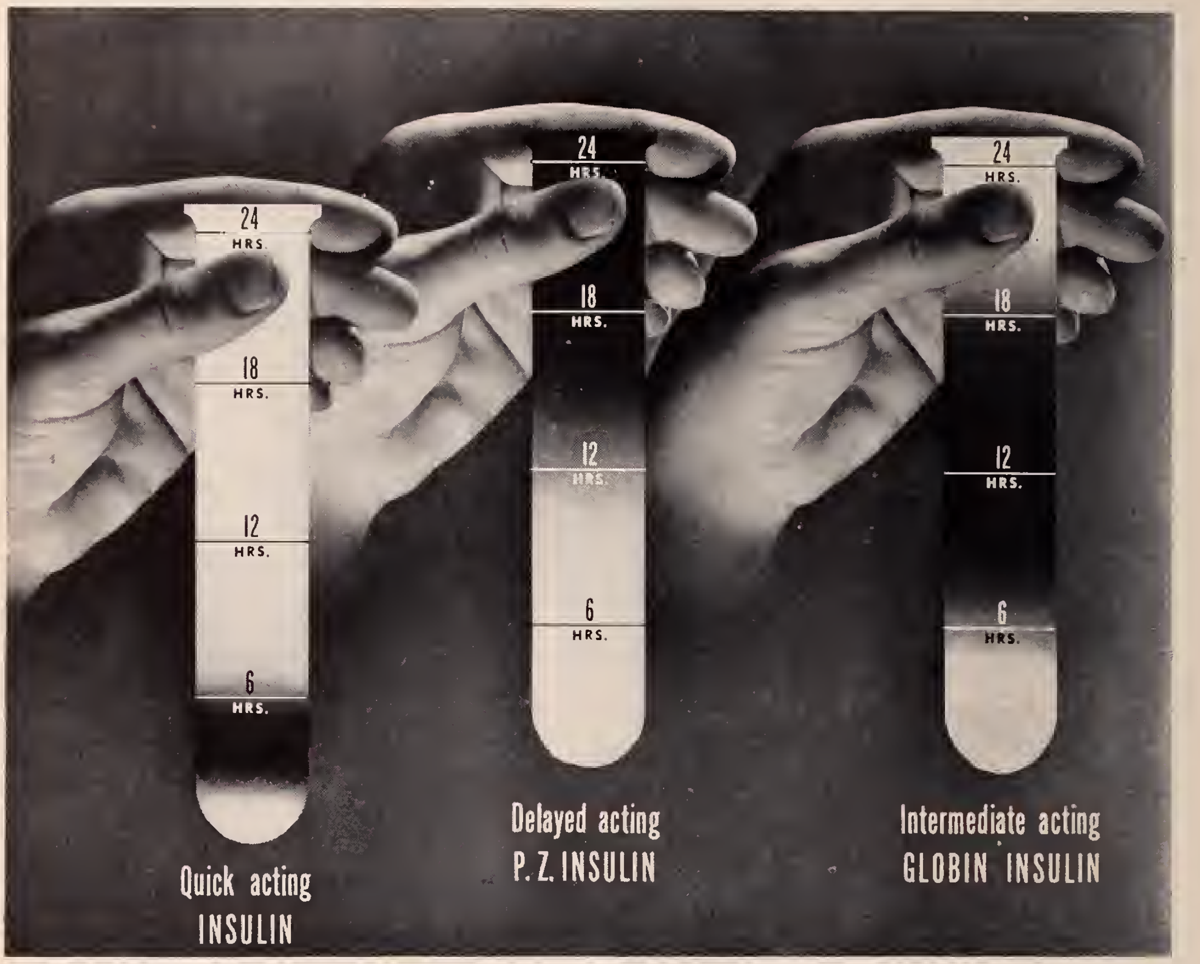
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PSYCHIATRIC TREATMENT OF PROMISCUOUS GIRLS

(Continued from Page 48)

Psychiatric Service was set up as a coöperative experimental project under the auspices of the United States Public Health Service, the California State Department of Public Health, and the City and County of San Francisco Department of Public Health, to provide for research and treatment of promiscuous girls in direct connection with a venereal disease clinic.

The chief objectives of the Service were to determine the personality and environmental factors that motivated the promiscuous behavior of the girls referred, and to determine to what extent psychiatric treatment might be effective in assisting them to make satisfactory adjustments, thus removing the likelihood of their behavior leading to the dissemination of venereal disease.

The study was primarily a clinical investigation from psychiatric, psychiatric social, and psychological approaches. Social histories on all patients were obtained. Psychiatric examinations were conducted routinely. Psychological studies including intelligence testing and Rorschach investigations were done on selected patients.

In the absence of a definition of promiscuity which could be used objectively, an arbitrary criterion was set up. The period of time considered was the six months immediately preceding registration in the Service. Promiscuous patients included married women who had engaged in any extramarital sexual relations within that period and single women who had had sexual relations with more than one man or with one man more than twice within the same period. Prostitutes were not included.

An analysis was made of 365 female patients, of whom 287 were classified as promiscuous and 78 as potentially

(Continued from Page 56)

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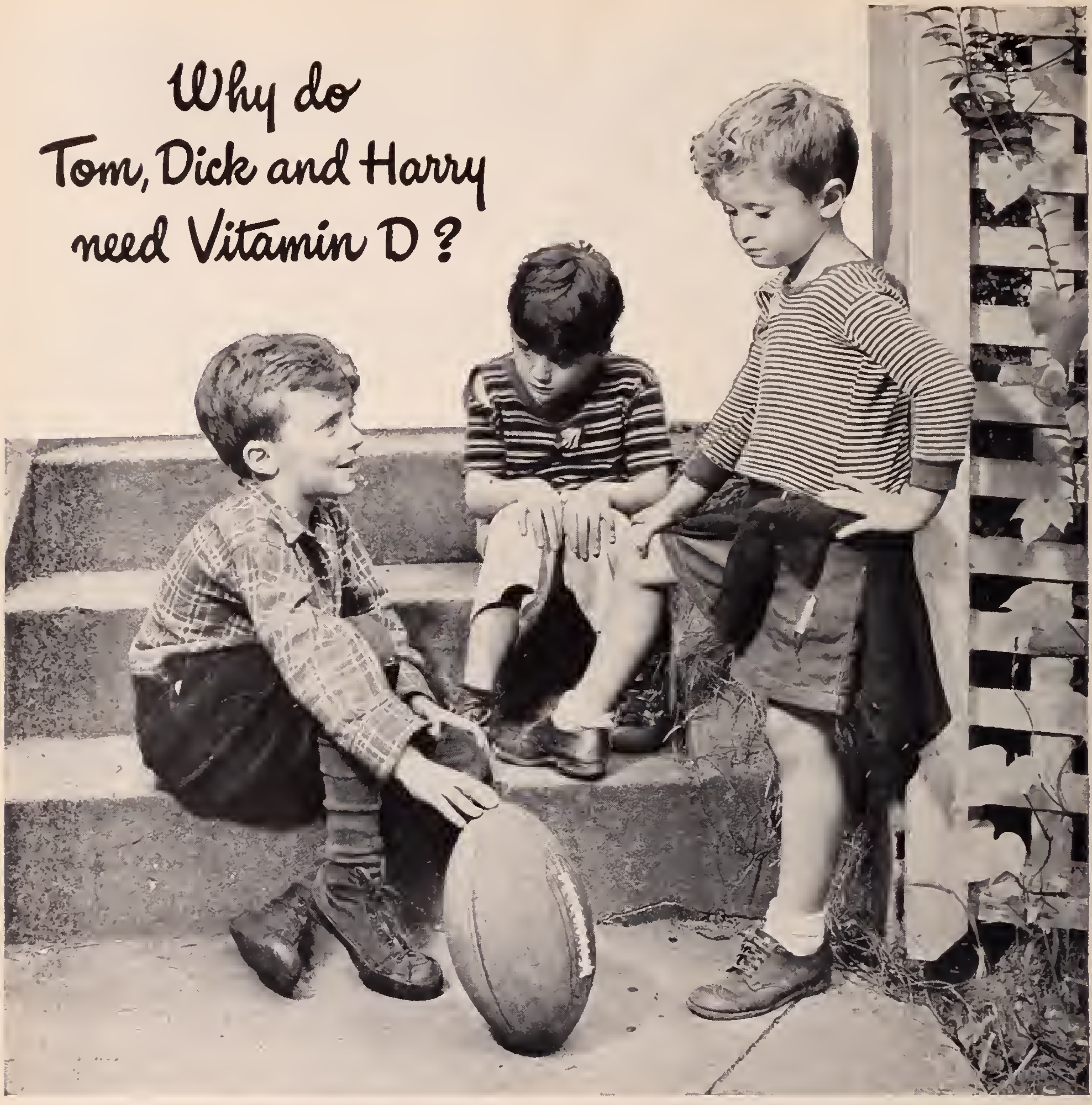

Growing children require vitamin D mainly to prevent rickets. They also need vitamin D, though to a lesser degree, to insure optimal development of muscles and other soft tissues containing considerable amounts of phosphorus . . . Milk is the logical menstruum for administering vitamin D to growing children, as well as to infants, pregnant women and lactating mothers. This suggests the use of Drisdol in Propylene Glycol, which diffuses uniformly in milk, fruit juices and other fluids.

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PSYCHIATRIC TREATMENT OF PROMISCUOUS GIRLS

(Continued from Page 52)

so. Eighty per cent were white, 20 per cent were nonwhite. The average age was 20.

Referral of patients to the Service was chiefly from the venereal disease clinic, although other community agencies referred some patients. Female patients in the clinic who were 22 years of age or younger were referred routinely, and those over 22 who were considered by a member of the medical or nursing staff of the clinic to be in need of service were admitted by special referral. The attendance of the patients at the Psychiatric Service was voluntary.

An extensive descriptive and historical work-up, including both social and personal factors, was made for each patient to determine whether some distinguishing characteristics might be found for promiscuous women. No single factor was found which, in itself, would either denote promiscuity or exclude it, but rather a nonspecific etiology was found. Unsatisfactory familial relationships, often marked by broken homes, and unstable inter-personal relationships were among the basic factors which, although not predetermining promiscuity, occurred frequently enough to suggest a direct relationship to promiscuous behavior. Sex instruction which the patient had received was usually described as being inadequate and unscientific. Conflicts of various types with reference to sex were seen in a majority of patients. Uneven development in physical, emotional, and social maturity within the individual patients was usually noted. The occurrence of neurotic tendencies was frequent, and there were suggestions that promiscuity might be considered as a neurotic equivalent in some cases. Environmental factors

(Continued on Page 60)

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[1] Am. J. Dis. Child. 66:1 (July) 1943.

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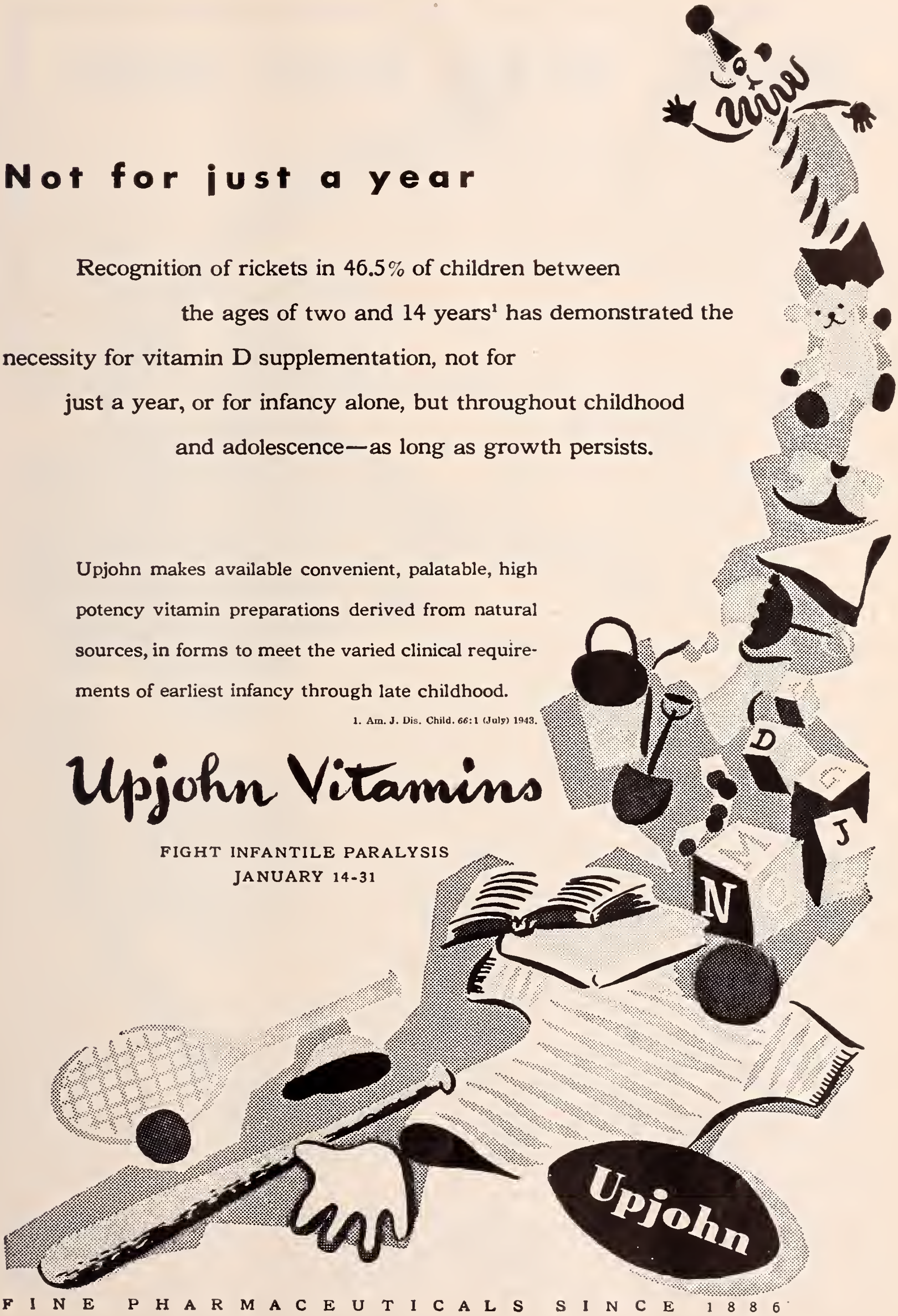

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PSYCHIATRIC TREATMENT OF PROMISCUOUS GIRLS

(Continued on Page 56)

such as unsatisfactory living conditions, the absence of community ties, and the making of casual friendships were found often to have contributed to the promiscuous behavior.

Slightly more than one-half of the promiscuous patients were found to be habitually so. In addition, there were groups who had sexual relations on a sustained affectional basis or on an episodic basis. Some patients could not be classified as to the degree of promiscuity.

Among those who were habitually promiscuous, one-half fell into the Conflictual group, whose promiscuity was the result of intra-psychic conflicts which were often in the sexual area. Nearly one-fifth were in the Dependent group, whose promiscuity was an outgrowth of immaturity and undue reliance on others. Another one-fifth were in the Maladapted group, whose sexual behavior was just one example of the activities which are characteristic of the unstable patient who lacks social responsibility and self-restraint. A small percentage fell into the Non-conflictual group, whose promiscuity seemed to present no conflicts within the patient or between her and her social group.

The response of the patients to the services offered varied. No significant differences were found as to the use of service on the basis of age. In general, the proportion of patients who took advantage of the services increased as the intelligence level rose. When groups of patients of similar intelligence in the different racial classifications were compared, no significant differences in the use of service were apparent. Approximately one-sixth of the patients availed themselves of intensive, prolonged treatmetn. An additional one-half of the patients utilized consultative service. Slightly more than one-third were not interested in service.

Changes observed in patients during the course of treatment suggested that they had benefited from the services given and in particular had reduced their promiscuity. Only 40 per cent of the patients given service could be followed up successfully after six months. The number was too few for conclusive deductions, but among those successfully followed up, 90 per cent were less promiscuous and 50 per cent had entirely ceased sexual relations outside of marriage.

The experience in this project indicates that, for the greater part, services can be used by this group of patients only if they are readily available in direct connection with the venereal disease clinic. The association of the Psychiatric Service with a venereal disease clinic thus provided an unique opportunity to reach patients who do not otherwise avail themselves of the services of community agencies, or in fact as a group are not reached by other agencies. Of particular importance has been the availability of service to patients in meeting the emotional experience associated with venereal disease at a time when anxiety has been aroused by the presence or probability of venereal disease.

It was concluded that psychiatric facilities can be used advantageously in connection with a venereal disease clinic to decrease, modify or eliminate promiscuity and resultant venereal disease among a suitable group of female patients who have been selected carefully and who voluntarily make use of treatment service. In addition, it was recommended that psychiatric treatment should be made available to promiscuous male patients who are in need of counseling.

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All of the hundred cases showed muscle spasm, they disclosed, but only 48 per cent also developed muscle weakness. All recovered sufficiently to walk without braces. Only one of the group had any deformity due to contracture of the muscles affected, the authors report.

Conclusions reached by the group include the following: muscle spasm always occurs in early poliomyelitis and constitutes one of the best ways of confirming the diagnosis; the drug neostigmine will relax the muscle spasm at least temporarily, but its permanent value is as yet unproved; and there is no proof that either the Kenny packs or the drug reduces the incidence of paralysis.

Parrot's Disease.—Judging by works of his that remain, much of which has appeared in various journals, the active professional interests of Jules Marie Parrot were centered in anatomic and pathologic studies, as well as those on the diseases of children. On the latter subject, he was especially concerned with athrepsia, and with the relation of certain changes of the bone structure through hereditary syphilis. To these studies he entirely devoted the latter part of his life.—Warner's *Calendar of Medical History.*

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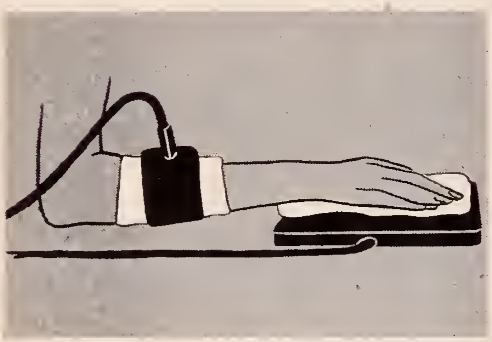

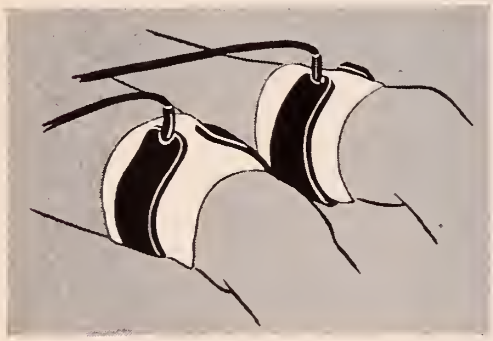

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The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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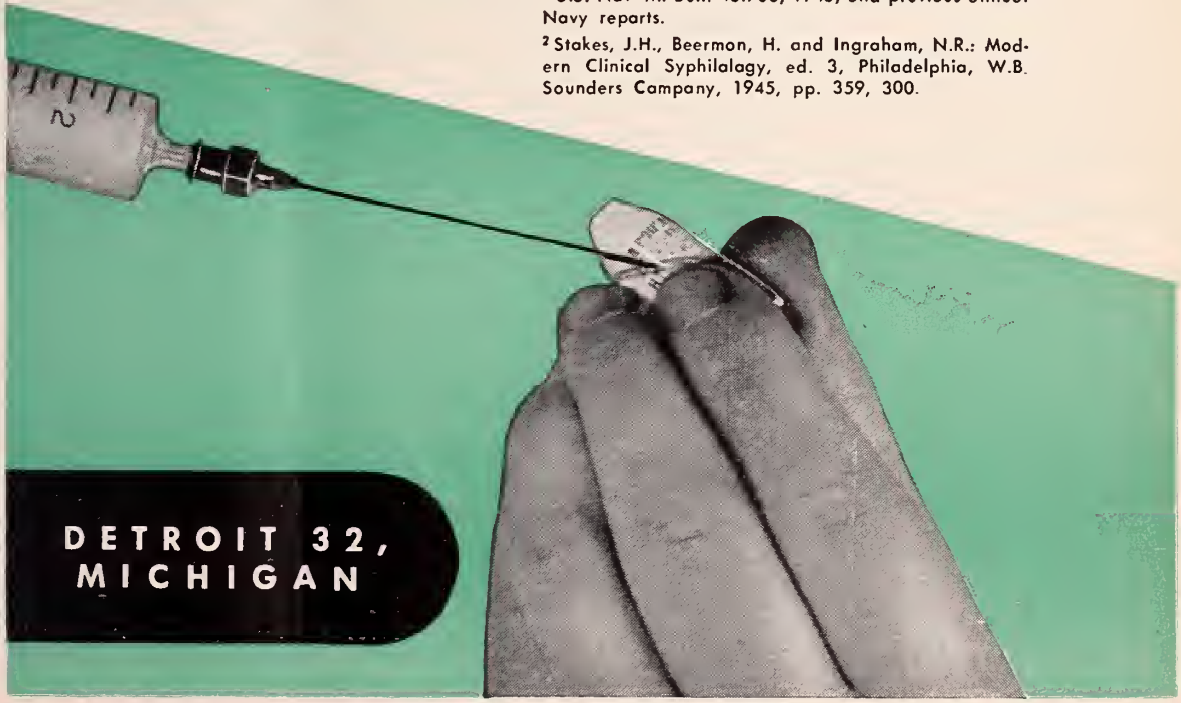

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[1] U.S. Nav M. Bull. 45:783, 1945, and previous annual Navy reports.

[2] Stokes, J.H., Beerman, H. and Ingraham, N.R.: Modern Clinical Syphilology, ed. 3, Philadelphia, W.B. Saunders Company, 1945, pp. 359, 300.

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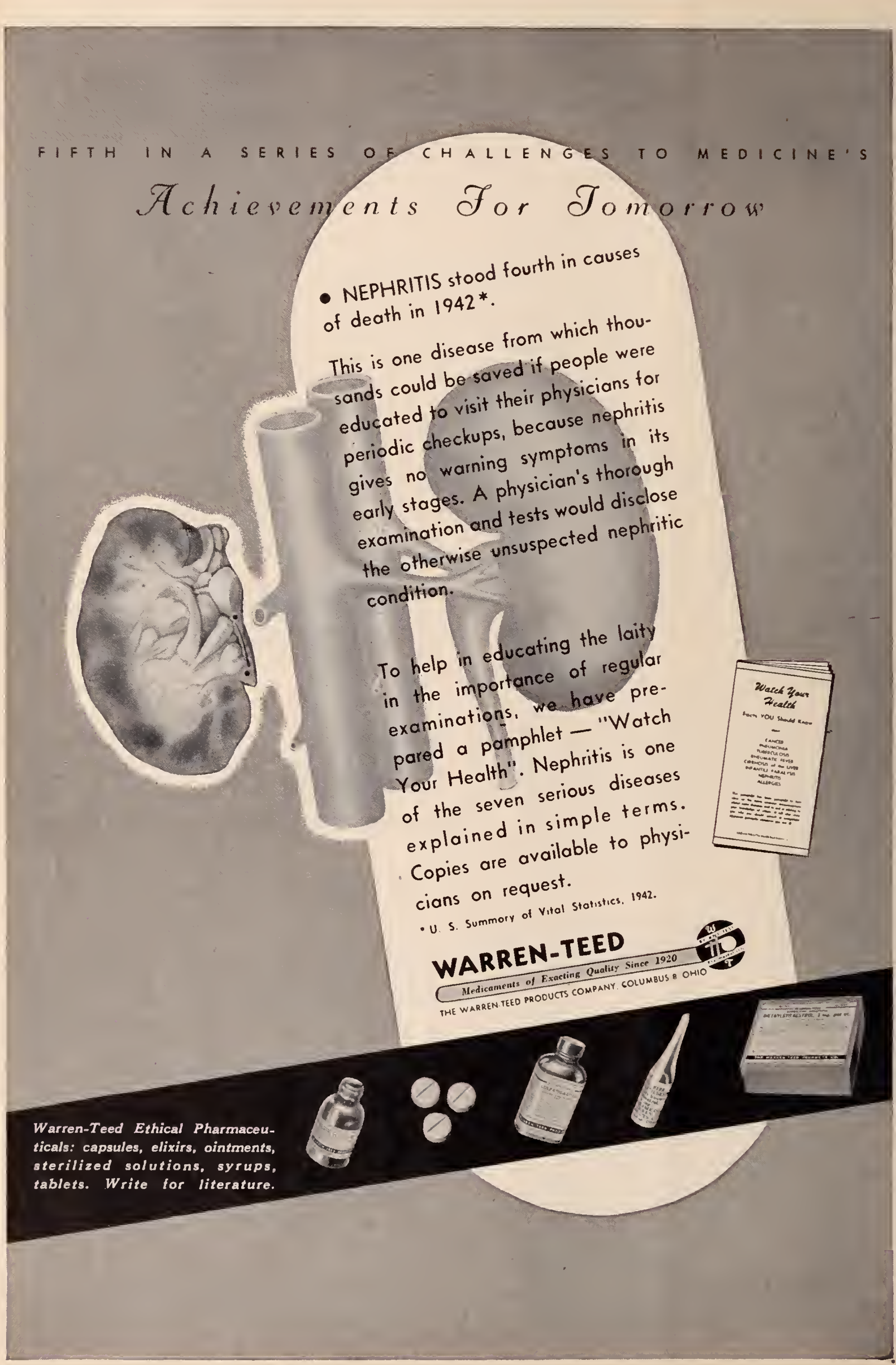
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Theory of Life, Disease and Death. By Morton Whitby, Member of the Royal College of Surgeons; Fellow of the Royal Society of Medicine, England; Honorary Urologist to St. Mary's Hospital; Urologist Specialist, Durban, South Africa. Late Surgeon Lt. Commander, British Navy; Urologist, Springfield Military Hospital, Durban, S. Africa; Consult. Surg., St. Margaret's Clinic for Tumors, London; Surgeon to the Bucks Diagnostic Clinic; Assistant Colonial Surgeon, Falkland Islands; Surgeon and Radiologist to McKenzie Hospital, British Guiana, South America; Surgical Registrar, London Lock Hospital; Urological Assistant, St. Peter's Hospital and West London Hospital and Resident Surgical Officer, St. Paul's Hospital. First edition. Cloth. Pp. 275 with 52 text illustrations and 21 charts. Chicago: Cutler Publishing Company, 1945.

Men Without Guns. Text by DeWitt Mackenzie, War Analyst of the Associated Press. Descriptive captions by Major Clarence Worden, Medical Department of the United States Army. Foreword by Major General Norman T. Kirk, Surgeon General of the United States Army. Cloth. Price, $5.00. Illustrated with 137 plates from the Abbott Collection of Paintings owned by the United States Government. Philadelphia: The Blakiston Company, 1945.

Science and Scientists in the Netherland Indies. Edited by Pieter Honig, Ph.D., Member of the Board for the Netherlands Indies, Surinam and Curaçao; Vice-Chairman, Netherlands Council, Institute of Pacific Relations; President, Intern. Society of Sugar Cane Technologists; Director, Rubber Research Institute, Buitenzorg; late Director of the Experiment Station of the Java Sugar In-

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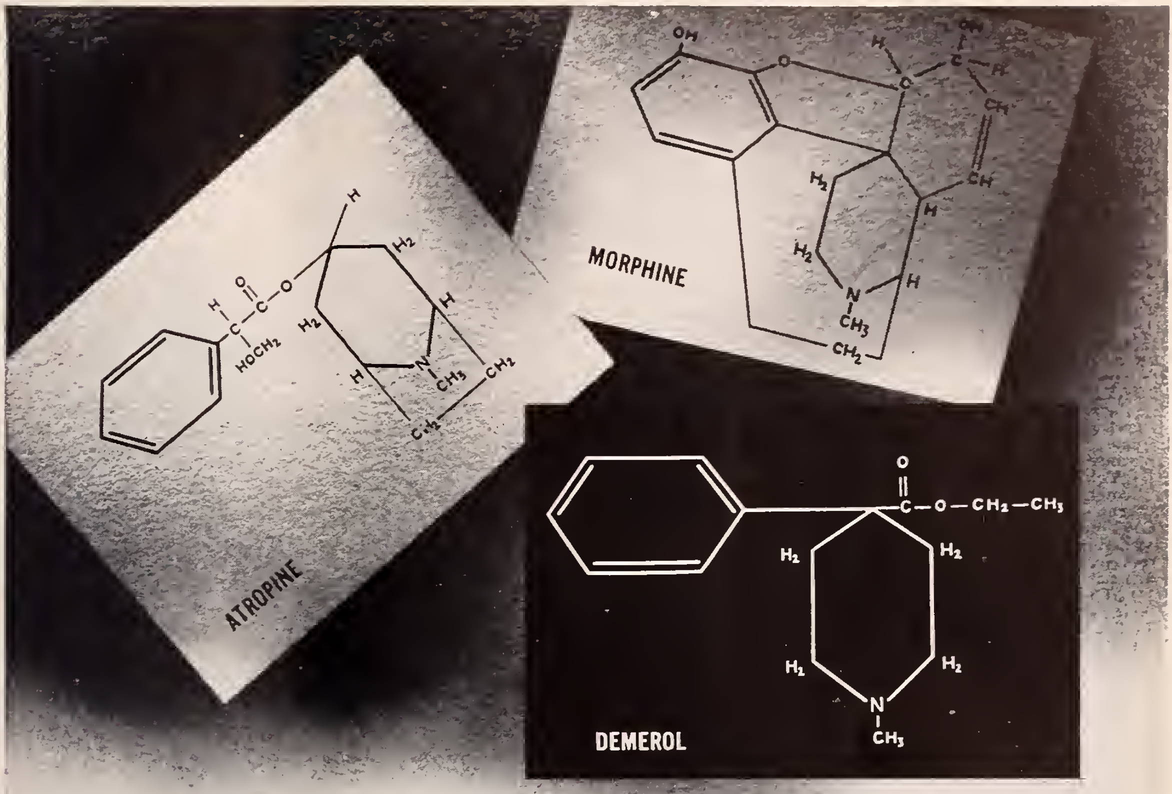

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(Continued on Page 50)

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BOOKS RECEIVED

(Continued from Page 7)

dustry, Pasoeroean; Associate Editor, "Natuurwetenschappelijk Tijdschrift voor Ned. Indië"; etc. and Frans Verdoorn, Ph.D., Botanical Adviser to the Board for the Neth. Indies, Surinam and Curacao; Managing Editor, "Chronica Botanica," "A New Series of Plant Science Books," and "Annales Cryptogamici et Phytopathologici"; Bibliographer, Arnold Arboretum of Harvard University; Hon. Secretary, Bot. Section, Intern. Union of Biological Sciences; Associate Editor, "Bryologist," "Farlowia," "Natuurwetenschappelijk Tijdschrift voor Nederlandsch Indië; etc. Cloth. Price, $4.00. Pp. 491, illustrated. New York City: Board for the Netherlands Indies, Surinam and Curacao, 1945.

Clinical Roentgenology of the Heart. Annals of Roentgenology, Volume XVIII, by John B. Schwedel, M.D., Associate Attending Physician, Medical Division, Adjunct Attending Physician, Dept. of Roentgenology, Montefiore Hospital, New York; Attending Electrocardiographer and Associate Visiting Physician in Medicine, Gouverneur Hospital, New York; Lieutenant Commander, M.C. (V) S. U.S.N.R. Cloth. Price, $5.00. Pp. 436 with seven hundred and forty-nine illustrations on two hundred and thirty-two figures. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1945.

BOOK REVIEWS

Diseases of the Breast: Diagnosis, Pathology, Treatment. By Charles F. Geschickter, M.A., M.D., Lieut. Commander, Medical Corps, United States Naval Reserve, Director of the Francis P. Garvan Cancer Research Laboratory; Pathologist, St. Agnes Hospital, Baltimore; with a Special Section on Treatment in Collaboration with Murray M. Copeland, A.B., M.D., F.A.C.S., Instructor in Surgery, Johns Hopkins Medical School; Visiting Surgeon and Assistant Oncologist, University Hospital, University of Maryland Medical School; Visiting Oncologist, Baltimore City Hospitals. Second edition. Cloth.

(Continued on Page 16)

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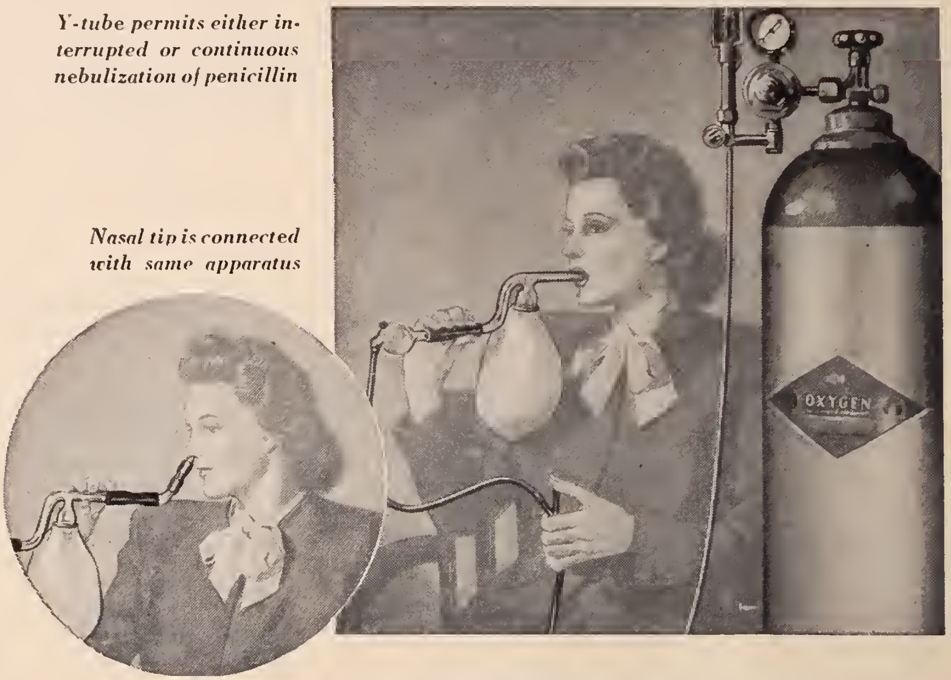

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Gerald L. Crenshaw, M.D., Oakland
Ina Gourley, M.D., Oakland

BOOK REVIEWS

(Continued from Page 12)

Price, $12.00. Pp. 826 with 593 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1945.

In recent years contributions to the etiology, the diagnosis and the treatment of mammary diseases have accumulated rapidly. Much of the progress made can be attributed to the different groups of specialists interested in these problems. The specialties concerned include surgery, radiology, obstetrics and gynecology, pathology, endocrinology and laboratory technology. In bringing together in this volume the work done in these diverse fields, the usefulness of this information to the general practitioner as well as to the specialties enumerated has been kept in mind.

A Primer of Electrocardiography. By George Burch, M.D., F.A.C.P., Associate Professor of Medicine, Tulane University School of Medicine; Senior Visiting Physician, Charity Hospital; Consultant in Cardiovascular Diseases, Ochsner Clinic; Visiting Physician, Touro Infirmary, New Orleans; and Travis Winsor, M.D., Instructor in Medicine, Tulane University School of Medicine; Assistant Visiting Physician, Charity Hospital, New Orleans. Cloth. Price, $3.50. Pp. 215, illustrated with 235 engravings. Philadelphia: Lea & Febiger, 1945.

This primer was written to enable the student who is unfamiliar with the subject to grasp a fundamental knowledge of electrocardiography in the most direct manner. Although no photographs of electrocardiograms are included, diagrams are liberally employed to illustrate typical electrocardiographic patterns and to depict certain conceptions more clearly. This primer is a supplement to the many monographs on electrocardiography that are now available and which should be consulted and used in conjunction with it.

While this book is necessarily somewhat dogmatic,

(Continued on Page 20)

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BOOK REVIEWS

(Continued from Page 16)

the authors think a certain amount of dogmatism is essential for the proper introduction to, and a clear understanding of such a subject as electrocardiography. Certain concepts of a special nature are eliminated not because they are deemed unimportant but in order to keep this presentation simple and brief. Further study of the subject is necessary before one should be permitted to undertake the serious responsibility of reading electrocardiograms clinically, and the authors hope that the student's interest will be aroused to such an extent that he will continue with more detailed study of the problem.

Plaster of Paris Technique in the Treatment of Fractures and Other Injuries. By T. B. Quigley, Lieutenant Colonel, Medical Corps, Army of the United States; Instructor in Surgery; Harvard Medical School (in absentia); Junior Associate in Surgery, Peter Bent Brigham Hospital, Boston (in absentia). Cloth. Price, $3.50. Pp. 107, illustrated. New York: The MacMillan Company, 1945.

The author states the construction of plaster casts has been called an art, but is rather a craft since it can be learned by anyone of reasonable intelligence with a modicum of manual dexterity. The author believes the plaster cast is the best splint in the armamentarium of the surgeon, stating it is cheap, durable, and when properly fashioned exactly fits the individual patient under conditions imposed by his particular injury.

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(Continued in Back Advertising Section, Page 58)

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TWENTY-FIVE YEARS AGO

(Continued from Page 114)

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From an Article on "Relationship Between Trauma and Malignant Disease from an Industrial Viewpoint," by W. Ophuls, M.D., San Francisco.—Before entering upon a discussion of the relationship of trauma to malignant disease from the point of view of one who wishes to determine fairly the connection of an industrial accident with the subsequent development of a malignant growth, it may be well to look upon the question from a purely scientific standpoint and to ask ourselves what warrant is there to assume, that there may be such a connection. . . .

From an Article on "How Can Medical Service Be Improved?," by Morton R. Gibbons, M.D., San Francisco.—To attempt to cover this subject in one-quarter of an hour without making some form of explanation or protest might be to acknowledge that medical service can be very little improved, if any. The contrary is the case. It may be vastly improved. . . .

My purpose is to take up for consideration a number of subjects, offering briefly some suggestions.

The importance of Industrial Medicine and Surgery is not appreciated by the rank and file of the profession

(Continued on Page 30)

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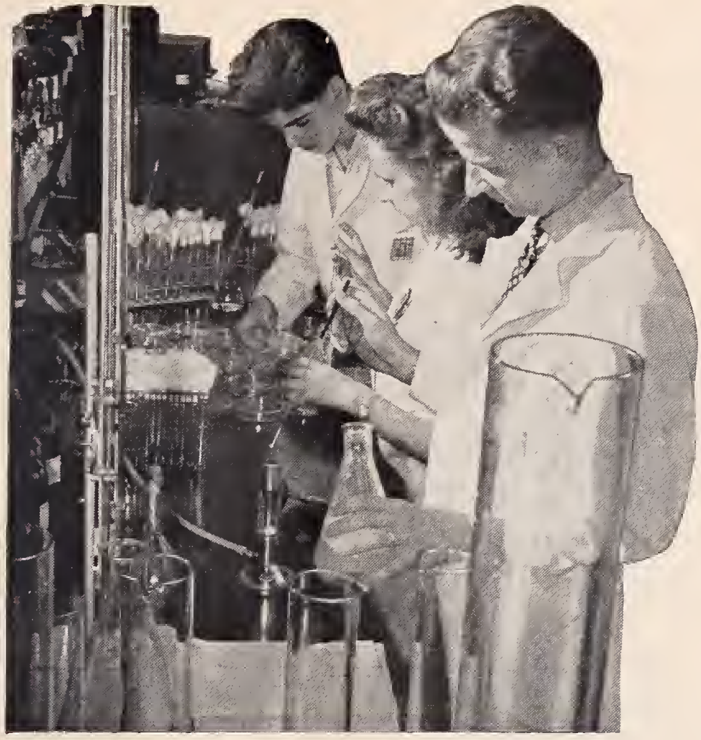

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**N. Y. State Journ. Med. 35 No. 11,590*
Laryngoscope 1935, XLV, No. 2, 149-154

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TWENTY-FIVE YEARS AGO

(Continued from Page 24)

It does not embrace simply the treatment of industrial injuries. It embraces all the phases of social medicine. The colleges are establishing courses in the subject. It embraces a large proportion of the total surgical and medical work. . . .

From an Article on "Bilateral Nephrolithiasis," by George W. Hartman, M.D., San Francisco.—Recent reports by various observers of the incidence of bilateral nephrolithiasis are very much in agreement. Braasch reports sixty-two cases among five hundred and sixty-six operations for calculus, a percentage of 12.3. Israel, in an exhaustive monograph on kidney and ureter stones, reports sixty-four cases among five hundred and seventy-two operations, or 11.2 per cent.

Our data includes forty-two cases of nephrolithiasis of all types. Of these, ten were bilateral, a percentage of 23.8. If reduced to the proportion operated it becomes 29.4 per cent. . . .

From an Article on "Urinary Incontinence and Its Operative Repair," by James R. Dillon, M.D., San Francisco.—Incontinence of urine results from inability of the sphincters to prevent the involuntary escape of urine from the bladder. There are a number of persons having varying degrees of urinary incontinence due to spinal cord diseases, tuberculosis and traumatic lesions, who are forced to wear a urinal on their person. The cystitis which usually accompanies these conditions with its complications and sequellae and the stench emanating from the urinal, impresses one with the miserable condition of

(Continued in Back Advertising Section, Page 34)

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CALIFORNIA
AND
WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 64 FEBRUARY, 1946 NO. 2

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EDITOR . . . . GEORGE H. KRESS, M. D.

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

Committee on Publications

George W. Walker, Chairman	Fresno	1946
F. Burton Jones	Vallejo	1947
R. H. Sundberg	San Diego	1948
George H. Kress, Secretary-Editor	San Francisco	ex officio

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . JOHN HUNTON

Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOuglas 0577)

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Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

FEDERAL VETERANS' ADMINISTRATION AND CALIFORNIA PHYSICIANS' SERVICE START CONTRACTUAL RELATIONS FOR MEDICAL SERVICE ON FEBRUARY 1, 1946

First Six Years of C.P.S. Have Been the Hard Years.—California Physicians' Service, a plan to provide medical service on a prepayment basis, and designed to be of special help to California citizens whose incomes were in the lower brackets, began its active work in 1939.

The plan came into existence at the instance of the California Medical Association, and that constituent state medical society may be said to have been, and still is the sponsor of C.P.S., the latter, however, being an entirely independent and separate corporation.

As is generally known, California Physicians' Service is a non-profit organization in which any licensed Doctor of Medicine who carries the usual minimum of malpractice coverage has the right to enroll as a Professional Member; a citizen who joins this prepayment plan being known as a Beneficiary Member.

From the time C.P.S. began its work, CALIFORNIA AND WESTERN MEDICINE has made an effort to present a progress report in each month's issue. Physicians who have read these, know that the path of C.P.S. has not been one covered with roses. One of the first Statewide prepayment plans to come into existence, and with practically no actuarial background to guide its formative activities, it was necessary for California Physicians' Service to proceed and learn through experience, and largely by the trial and error method.

In spite of many handicaps, C.P.S. is a going concern that, during the past six years, has been of much service to citizens and physicians of California. Readers who may wish to refresh their memories concerning the present status of C.P.S. will find a report in last month's issue of CALIFORNIA AND WESTERN MEDICINE, on page 44; and other editorial comment on page 4. In the current issue, additional information may be gleaned by referring to pages 88-89 and 92.

The above is here given as a brief foreword for comment on an important contract signed on December 31, 1945, by the representatives of the Federal Veterans' Administration and California Physicians' Service. Concerning the same, additional information follows.

What the Veterans' Administration-California Physicians' Service Contract Provides.—In last month's OFFICIAL JOURNAL, on page 4, mention was made that the Michigan State Medical Society, using its "Michigan Medical Service" as a fiscal agent to contract with the Federal Government (Veterans' Administration, through General Omar N. Bradley, Veterans' Administrator, and Major-General Paul R. Hawley, acting surgeon general) had made a formal agreement with V.A. on December 28, 1945, whereby home medical service would be rendered to veterans entitled to medical care under Veterans' Administration laws and directives.

Four days later, on December 31, 1945, a somewhat similar contract was signed by representatives of V.A. and C.P.S., the mutual arrangements to become operative on February 1, 1946.*

* * *

On Provisions in the V.A.-C.P.S. Contract.—Because of the future importance and also the implications for extension of the work of California Physicians' Service, the OFFICIAL JOURNAL gives below the text of the letter sent out about January 31st by C.P.S. President Lowell S. Goin, in which some major provisions of the V.A.-C.P.S. contract are indicated:

(COPY)

Subject: Veterans' Administration: Care of Veterans Under California Physicians' Service Contract

CALIFORNIA PHYSICIANS' SERVICE
153 Kearny St., San Francisco 8, Calif.
EXbrook 0161

Dear Doctor:

It is with great pleasure that we announce that California Physicians' Service has been nationally honored and recognized for what it has done in the field of promoting better health care through the development of a prepaid medical plan. The Veterans' Administration in Washington, D. C. has entered into a contract with our organization for the purpose of providing medical care to our veterans for service-connected disabilities. This contract goes into effect on February 1, 1946, and places veterans in California who otherwise would be cared for through governmental medical agencies under the care of the private physicians who are members of C.P.S.

Major-General Paul R. Hawley of the Veterans' Administration in Washington is desirous that as much government red tape be eliminated as possible by simplification and curtailing forms; thereby facilitating the flow of medical care to the veterans. Simple details of procedure, being worked out by California Physicians' Service and the local Veterans' Administration, will be forwarded to you as soon as they are completed.

At present the plan will operate generally as follows:

1. Determination of eligibility for care will be made by the Veterans' Administration *before* the doctor is asked to render diagnosis or care.
2. After receiving such authorization, the veteran selects his own physician from amongst the C.P.S. professional members in his own community.
3. The physician, after examining and treating the veteran, reports his diagnosis and extent of treatment rendered to C.P.S. on a monthly basis.
4. Upon receipt of the report, C.P.S. will send a check to the physician for his services. Pricing will be done in accordance with the fee schedule attached hereto at the *par* unit value of *$2.50*.
5. At the end of each month C.P.S. will bill the Veterans' Administration, according to the fee schedule, for all fees paid.
6. The amounts as set forth in the fee schedule are payment in full for each veteran's service.

While this is a great opportunity for the medical profession to further establish the principle of free choice of physicians in the care of veterans, it is also obviously a tremendous responsibility. Should we fail to do a perfect job, and if individual veterans are not satisfied with the consideration accorded them, the consequences are not difficult to foretell. California Veterans' organizations have been staunch allies in our fight against State Medicine. We have a splendid opportunity now to justify their confidence. Let us measure up to that opportunity.

In order that C.P.S. may know those physicians who are prepared to render care to the veterans on this program, and in order that every physician in the State may have an opportunity to enroll in C.P.S. if he has not already done so, we ask that the enclosed business reply card be filled out and mailed *immediately*. Please be sure to answer all the questions on the card and sign your name and address before mailing. *Under all conditions* and regardless of your position with respect to the program PLEASE RETURN THE CARD as the public interest and the interest of th medical profession require that our administration be superior to government red tape.

Very truly yours,
(Signed) LOWELL S. GOIN, M.D.,
President, California Physicians' Service.

* * *

Copy of Reply Card sent to physicians by C.P.S., follows:

CALIFORNIA PHYSICIANS' SERVICE—VETERANS' CARE PROGRAM

I do (....) do not (....) elect to accept veterans as patients under the California Physicians' Service—Veterans' Administration plan.

I am now a C.P.S. professional member (....) (....).
yes no

I am not now a C.P.S. professional member, but desire to enroll (....) (....).
yes no

My specialty is ....

Signature ....

Address ....

Please Return Promptly ....

---

* For a State as large as California it will be necessary for Veterans' Administration to set up a regional office to maintain contacts with this V.A.-C.P.S. work. Hence, a delay of several weeks, before all activities are in operation.

The V.A.-C.P.S. Contract Will Permit Maintenance of Private Practice and Physician-Patient Relationship on an Equitable Basis.—In California and Western Medicine for January, on pages 45-46, other information was given concerning the nature of the contract through which California physicians will be able to give professional service to veterans in the homes of veterans; thus making for medical care on a private practice, instead of a governmental-institutional basis. In other words, private practice will be maintained and with no loss of the individual physician-patient relationship. The physician will be paid for his services according to the provisions of a stipulated and equitable fee schedule, copies of which were forwarded with C.P.S. President Goin's letter. (Also will appear in March California and Western Medicine.)

A physician rendering medical care to a veteran under the conditions agreed upon, will receive the fee for his services from C.P.S., since C.P.S. is acting in the rôle of a fiscal agent or entity, with which the governmental agency (V.A.) is permitted by law to enter into contract. It would be impossible for V.A. to enter into contract with thousands of physicians.

On page 46 of the January California and Western Medicine article above referred to, it was stated that an estimate of the number of veterans resident in California was 1,300,000. These figures indicate the significance of the V.A.-C.P.S. contract. In the current issue, figures even larger are mentioned in a Sacramento dispatch (see page 95.)

* * *

California Physicians Have Now a Great Opportunity for Service, and in More Ways than One.—As stated by C.P.S. President Lowell S. Goin in his above letter:

> "While this is a great opportunity for the medical profession to further establish the principle of free choice of physicians in the care of veterans, it is also obviously a tremendous responsibility. Should we fail to do a perfect job, and if individual veterans are not satisfied with the consideration accorded them, the consequences are not difficult to foretell."

Therefore, the prompt and cordial coöperation of every California Doctor of Medicine is urged, in order to make certain that the V.A.-C.P.S. contract will be one of genuine success and satisfaction to all concerned.

The physicians of the states of Michigan and California, who were pioneers in establishing voluntary prepayment organizations to render medical care, have it now within their power to demonstrate the value of the organizations they brought into being.

If Michigan and California are successful in their Veterans' Administration programs, other constituent state medical societies will no doubt promptly seek similar contractual relationships with Veterans' Administration.

However, if Michigan and California fall short in this, the proponents of Compulsory Health (Sickness) Insurance will have potent arguments to present in favor of their Political Medicine schemes.

Every California physician has here a definite responsibility. This time, all Doctors of Medicine must work together for attainment of the major objective of rendering a high quality medical service to a group of veterans who are worthy of the best that scientific medicine can offer.

We must not fail.

SEVENTY-FIFTH ANNIVERSARY CELEBRATION OF THE FOUNDING OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION, AND—ITS "HISTORICAL BULLETIN"

Diamond Jubilee Dinner on January 31, 1946.—In last month's issue of the Official Journal, on page 3, brief comment was made concerning the founding of the Los Angeles County Medical Association, which took place on January 31, 1871, some 75 years ago. (In current issue, see p. 86.)

In 1870, the U. S. census credited the City of Los Angeles with a population of 5,614. Today, Los Angeles County has 3,456,277 residents, the estimated quota of the City of Los Angeles being 1,769,659! (These statistics from an item in California and Western Medicine, for January, 1946, on page 59.)

* * *

Los Angeles County Medical Association Has Kept Step with Los Angeles County in Growth.—The Los Angeles County Medical Association was founded by seven physicians. Today this component county unit is credited with 3,400 members, exclusive of several hundred who have been given leaves of absence. Los Angeles County Medical Association is probably the third largest component county medical society in the United States, being exceeded in number only by the New York and Chicago-Cook County societies.

With a record of such remarkable growth in number of members, and notable achievements in organized and scientific medicine, little wonder that this important county unit deemed it proper to honor the memory of its founders by a Diamond Jubilee dinner on the evening of Thursday, January 31, 1946, in the Bowl of the Hotel Biltmore, at which members and guests in excess of 800 were present.

In a succeeding issue of the Official Journal may appear comment on the delightful dinner to which members of the C.M.A. Council and their ladies, the living ex-presidents of the California Medical Association, with others, were invited as guests of the Los Angeles County Medical Association.

* * *

75th Anniversary Number of "The Bulletin of the Los Angeles County Medical Association" is a Most Valuable Contribution to C.M.A. Archives.—Praiseworthy as was the enjoyable evening of January 31st last, it must be conceded that of as great and perhaps more importance was the appearance and distribution of the 75th Anniversary Number of *The Bulletin* of the Los Angeles County Medical Association.

The Bulletin for this occasion increased its usual size until it became a publication of 202 pages, made up almost entirely of historical text, and replete with numerous relevant and very interesting illustrations taken from records of years ago.

The many pages of important historical memorabilia contained in the Diamond Jubilee number of *The Bulletin* were gathered at expenditure of much effort and time in libraries in Los Angeles, Sacramento and San Francisco by *The Bulletin's* editor, Dr. E. T. Remmen, who had the assistance of a group of friends and co-workers. For this work, to him and his associates, many thanks and much praise.

The 75th Anniversary Number of *The Bulletin* is a valuable addition to the archives of the California Medical Association, the more so because up to the present, our own State Association has never seriously taken up this work.

In a recent issue of the OFFICIAL JOURNAL (CALIFORNIA AND WESTERN MEDICINE, Nov., 1945, p. 248), attention was called to a $25,000 appropriation from the Mayo Properties Association of Rochester, to be used in the production of a volume, "History of Public Health in Minnesota."

The History of Medicine in California, relative to medical organization and practice and public health endeavors, is certainly as extensive as that of Minnesota; and it is to be hoped in the near future, the gathering of historical data concerning the past of the California Medical Association, its component county societies, former members, and the achievements of workers of years ago, may take on definite form, for preservation and permanent record. If the collection and compilation of valuable historical data is not soon started, much of the material may be irretrievably lost.

The Los Angeles County Medical Association is to be congratulated on having paved the way for a similar effort on a state-wide basis.

Our hope,—That other component county societies will emulate the example, so splendidly exemplified.

In due course, copies of the historical number of *The Bulletin* will be placed in the Lane, U.C., San Diego, Riverside, Los Angeles, Army, Congressional, and other medical libraries, to permit physicians to whom historical writings have lure, to scan or peruse the story of what has been so well accomplished in the three-quarter century existence of the Los Angeles County Medical Association.

Our wish,—That in the 75 years yet to follow, as great and even greater progress may be recorded.

This Year's C.M.A. Annual Session

California Medical Association will hold its 75th Annual Session in Los Angeles Tuesday, May 7-Friday, May 10, 1946. Make note of dates.

STATE UNIVERSITY MEDICAL SCHOOL APPROPRIATIONS—$4,000,000 FOR ADDITIONS TO MEDICAL CENTER IN SAN FRANCISCO, AND $7,500,000 TO ESTABLISH A NEW MEDICAL DEPARTMENT AT U.C.L.A., IN LOS ANGELES

State Assembly and State Senate Approve Substantial Appropriations.—Under date of February 5, press dispatches from Sacramento gave the important news that two of the items in Governor Earl Warren's call for the special session of the California Legislature, now sitting, had received the approval of the Senate, the bills having been introduced in the Lower House, at an earlier date by Assemblymen M. Philip Davis of Los Angeles and Gardiner Johnson of Berkeley, and given approval by that body.

News item follows:

> "$4,000,000 FOR U. C. HOSPITAL
>
> *"$7,500,000 Also Voted for U.C.L.A. Medical School Facilities*
>
> "Sacramento, Feb. 5.—Two bills appropriating $11,500,000 received final legislative passage today, paving the way for a new $7,500,000 medical school at U.C.L.A. and a $4,000,000 improvement program at the University of California's San Francisco medical center.
>
> "The two items were included in the Governor's $154,000,000 postwar construction program. . . ." San Francisco *Examiner*, February 6.

* * *

Governor Warren Is Expected to Sign the Appropriation Bills.—Governor Warren, in his call for a special legislative session, having urged appropriations for the U. C. Medical School in San Francisco and the proposed U.C.L.A. Medical School, and the bills having been accepted with practically no opposition in either Assembly and Senate, it may be assumed that when the two measures are placed on his desk for consideration, he will attach his signature and so enact them.

* * *

These Medical School Appropriations Are Welcomed by California Physicians.—Physicians throughout the State should take pleasure in knowing that through these appropriations, advances in scientific medicine will be promoted and the interests of the public health promoted.

U. C. Medical School in San Francisco.—The present University of California Medical School, with first two years of instruction in Berkeley, and last two in San Francisco, is the successor of Toland Medical College, established in 1862. Toland College became the U. C. Medical Department in 1872. The present arrangement of freshman-sophomore work in Berkeley, with junior-senior clinical division in San Francisco, was instituted in 1906.

The site of the clinical department in San Francisco, at Third and Parnassus, is now known as the U. C. Medical Center. The appropriation of $4,000,000 will permit long needed improvements and expansion of the work at the Medical Center; and will be more than welcome not only to the members of the teaching staff, but to the many physicians in the northern section of the State who, during many years, have availed themselves of staff rounds facilities.

U. C. Medical School at U.C.L.A., in Los Angeles.—Concerning the new school to be established in Los Angeles, in conjunction with the University of California at Los Angeles, plans have not been publicized. Little more is known at this time, than the action recently taken by the U. C. Regents, regarding which editorial comment was made in California and Western Medicine for November, 1945, on page 208.

In Los Angeles, two Class A medical schools have been carrying on undergraduate work—the present University of Southern California Medical School since 1928, and the College of Medical Evangelists since 1909.

Ample clinical facilities are provided through the large Los Angeles County General Hospital, a public hospital, which in the year ending July 1, 1945, admitted 58,024 patients, the bed-patient capacity being about 3,000.

What portion of the instruction in the new medical school will be given on the Westwood campus of U.C.L.A. has not been stated. Whether and how the out-patient facilities of the present Los Angeles Medical Department of the University of California at 737 North Broadway will be utilized is also not known. This property, extending from Broadway to Castelar Street, was formerly owned by a non-profit corporation composed of faculty members of the former College of Medicine of the University of Southern California, who deeded the property to the University of California in 1909, with the stipulation that the U. C. Regents should maintain in Los Angeles a medical school. To the writer, who is the only living member of the non-profit corporation that gave the North Broadway property to the University of California, the recent action of the University of California to establish a high grade medical school in Los Angeles naturally has a special interest. The development of this new medical school in California will be watched with much interest. (Bill was signed Feb. 20, 1946.)

PRINTING PROBLEMS IN RELATION TO CALIFORNIA AND WESTERN MEDICINE

Why Delay in Appearance Has Been Unavoidable.—Among readers of California and Western Medicine, there can be some who may have been annoyed at the somewhat irregular appearance of the monthly issues. The fact is acknowledged and what is here stated is in way of explanation.

During the last five years, the schedules and procedures that were in vogue in the offices of many physicians through the late thirties were often seriously disarranged. A similar experience was had by many business groups.

In the printing trade, for instance, securing an ample supply of paper stock was not a simple matter. Witness, the constant appeal of newspapers to turn in all old paper for re-use and remake in order to conserve newsprint. However, paper stock, ink and other supplies were only a part of the burdens of printing office executives. The skilled manpower so much needed, such as composers, press and bindery men and assistants, —the lack of these was also part of the problem during the war years. And, little could be done about it. The major military conflicts had first to be won.

California and Western Medicine has suffered with other publications. Appreciation is expressed that practically no criticisms came to the editorial desk,—a tribute to the coöperative and kindly thought of C.M.A. members. For this, thanks.

* * *

Comments of the New York State Journal of Medicine.—It is possible, however, that some readers may have felt that certain delays and other procedures should not have happened. For such colleagues, the perusal of an excerpt from an editorial in the *New York State Journal of Medicine* may be reassuring.

Quotation follows:

> "Necessarily the war, difficulties with paper, and delays in printing-plant schedules have interfered with normal production. . . . Restrictions on travel and the holding of meetings has severely cut the normal inflow of scientific articles which ordinarily have been derived from the Annual and District Branch meetings. These difficulties have taxed greatly the resourcefulness of the Managing Editor and the associate editors in coping with this situation. . . .
>
> "The *Journal* has been late, it is true, but it has eventually appeared. The good nature of our members, our subscribers, our printers, and advertisers under these circumstances has been a constant source of gratification to the *Journal* management. Apparently we have a host of friends whose patience is only exceeded by their good manners. We want them to know that we are appreciative, and that we shall not abuse the courtesy which they have extended to us in a difficult period. On our part every effort will be made, as rapidly as circumstances permit, to raise the standards of the *Journal*, to bring it out on schedule, and to increase the amount of scientific material published."

Müller's Sign.—Doctors and students alike come from all over the world to attend the clinical lectures of Friedrich von Müller in Munich. The father of modern diagnostic routine, he possessed the ability to explain the most difficult things with the utmost clarity, and this made his clinic one of the most frequented in Europe. He had himself been a pupil of Voit and Gerhardt. Increased metabolism in exophthalmic goiter was first noted by Müller in 1893.—Warner's *Calendar of Medical History.*

Sir Joshua Reynolds (1723-1792).—It is the year 1789. Reynolds, finishing a portrait of Lady Beauchamp, is suddenly annoyed by a dimness in his left eye. Rubbing does not remove it and he must leave off work. Within ten weeks, the sight of the eye is entirely gone, and he must give up painting permanently. Though Reynolds has up to this time been practically free from physical disabilities, he accepts this calamity calmly and even cheerfully. A grave liver derangement, diagnosed too late, was the cause of his death three years later.—Warner's *Calendar of Medical History.*

EDITORIAL COMMENT[†]

"SUBSTRATE COMPETITION" THERAPY

A plausible new theory, applicable to the therapy of a wide range of bacterial toxins, is suggested by Zamecnik[1] and associates of Harvard University. The theory is a generalization from their study of the non-specific neutralization of Cl. welchii toxin by organ-specific lipids.

It was shown by earlier investigators[2] that Cl. welchii manufactures an enzyme which hydrolyzes lecithin. This lecithinase is apparently identical with the alpha toxin in Cl. welchii filtrates. Since this toxin destroys tissue cells[3] its effect is presumably due to the action of this enzyme on the lipids of the cell surface. It occurred to the Harvard investigators that intravenous injections of similar lipids might divide the action of Cl. welchii toxin between hydrolysis of the added lipids and the cell surface, and thus reduce its cytotoxic action.

To test this hypothesis lecithins and total lipids were extracted from human erythrocytes, beef brain, swine liver, eggs, soy beans, etc. It was found that 0.1 per cent suspension of several of these total lipids would completely inhibit in vitro hemolysis by Cl. welchii filtrate. To test their in vivo action mice weighing 20 to 30 grams were injected intravenously or intraperitoneally with the most promising of these lipids, the dosage ranging from 0.2 to 1 gram per kilo. The lipids were administered as 2 to 10 per cent emulsions in single or divided doses. The volume of injected fluid ranged from 0.1 to 0.5 cc. About 10 minutes later the treated mice and an equal number of normal controls were each injected intravenously or intraperitoneally with a single or divided dose of tetanus alpha toxin. The dose for each mouse was usually from 10 to 20 LD_{50}.

In a typical test 18 control mice were thus injected. Of these 17 died (mortality 95 per cent). Of 16 mice previously injected with egg yolk lecithin, none died (mortality 0). Soy bean phosphatides in contrast furnished no protection, there being a 100 per cent mortality in both the treated and control series. Most of the effective lipids were well tolerated on both intraperitoneal and intravenous injections. For examples 150 mg. of hog liver, hog erythrocyte or human erythrocyte lipids could be injected intravenously into mice without deleterious effects. This is 15 times the quantity necessary to provide complete protection against multilethal doses of alpha tetanus toxin.

These results were confirmed on dogs. In one series a 10 per cent aqueous emulsion of human erythrocyte total lipids was given by slow intravenous drip over a 4 hour period to a series of dogs. The total dose varied from 1.1 g to 1.6 g per kilo. Each dog was then given 220 LD_{50} per kilo of Cl. welchii alpha toxin by slow intravenous drip over a 3 hour period. An equal number of non-treated dogs were injected as controls. All control dogs died with extensive intravascular hemolysis within 8 hours after beginning the toxin administration, autopsies revealing the presence of hemolyzed fluid in the pleural and peritoneal cavities, extensive pulmonary edema, with hemorrhage and congestion of other viscera. At the end of 8 hours the dogs previously given erythrocyte lipids were in good condition. Throughout the course of the experiment the plasmas of these dogs showed minimum hemolysis, never more than 0.1 per cent. Certain of the treated dogs were sacrificed at the end of a 10 hour period. Necropsy findings were essentially negative.

From these and other data, Zamecnik concludes that certain organ-specific lipids function as an effective "competitive substrate," protecting tissue cells from the cytotoxic action of alpha tetanus toxin. When knowledge of the substrate specificity of other bacterial toxins becomes available he believes it should be possible to apply the new theory of "substrate competition" to the prevention or treatment of numerous other bacterial diseases.

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Legislative Battle Begins for Surplus State Fund

Sacramento, Jan. 8.—(UP.)—Opening bid of the Warren Administration to keep surplus State money for State or related construction was to come before the Legislature today in a bill asking 154 million dollars for strictly State use, instead of a previous 120 million dollars.

Assemblyman Wollenberg (R., San Francisco), who has handled Administration legislation in the past, announced he would present the measure. It conflicts with plans of a strong bloc to obtain 90 million dollars of the State's 235 million dollars in postwar construction money for city, county and other local government public works.

The dispute over the surplus funds loomed as one of the bitterest of the special session.

The Governor asked also for action on problems of veterans, on housing, employment, racial relations, money for child care centers and a sickness insurance system. Some legislators predicted the Governor's chances of getting the major portion of the program enacted would depend on his willingness to compromise on postwar construction.

Mr. Wollenberg's bill makes a direct bid for 34 million dollars of the 90 million dollars sought by the city and county bloc for local use.

Biggest items in the bill are 30 million dollars for the University of California, 57 million dollars for State mental hospitals, 15 million dollars for State buildings, 13 million dollars for State colleges and special schools and 12 million dollars for prisons.

The Governor also has disclosed he will ask for a further 50 million dollars for housing, slum clearance, rural school construction, flood control and miscellaneous items.—San Francisco *Examiner*.

[†] This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

Scientific and General

MALPRACTICE SUITS—THE RISING TIDE*

LOUIS J. REGAN, M.D., LL.B.
Los Angeles

PRIOR to the beginning of this century few malpractice claims were advanced against physicians. After 1920, the malpractice claims incidence began to rise sharply. The depression decade of the 1930's witnessed a tremendous increase in the number of claims and suits. In 1937 about 4,000 physicians were sued for malpractice in the United States. With war prosperity there was some reduction in the number of claims but there is already indication that, in this respect, the war is over; that it is again open season in so far as doctors are concerned.

PROCEDURES DESIGNED TO PROTECT THE PUBLIC

It is not denied that there are meritorious malpractice claims—cases where a patient suffers injury due to the ignorance or negligence of his medical attendant The burden and the duty of dealing with this problem is, in public opinion, placed squarely on the medical profession. The responsibility is ours; we acknowledge it and are endeavoring to meet it. There is a primary filtering of the incompetent and unprincipled by the State Board of Medical Examiners. County Medical Association reduce the opportunities of the charlatan to mulct the public. Applicants for membership in medical associations are carefully surveyed and weighed as to professional qualifications and personal integrity. Hospital staffs endeavor to exclude the poorly qualified and the careless physician from the hospital wards. Practicing physicians are constantly encouraged, and they are offered opportunities, to keep abreast of advances and developments in the profession. The organized group has, however, little disciplinary power over its members and none at all over non-members. Its force, its influence, is largely moral, exercised through educational activities.

As a group we are anxious to do everything possible to protect the patient from the incompetent or dishonest physician. We are aware that nothing so injures the public relations of the profession, its prestige and standing in the public eye, as does the wave of misunderstanding and ill-will engendered by the great number of malpractice claims. It is obvious, however, that although the public are urged to seek out well qualified physicians to care for them, they do not have to, and often do not, follow this good advice. In the public interest we have sought and continue to seek the passage of a basic science law.

PUBLIC IS INDIFFERENT CONCERNING UNJUSTIFIED MALPRACTICE CLAIMS

The more serious factor in the malpractice problem is created by the large and constantly increasing number of unjustified malpractice charges which are being brought against physicians. The seriousness of the situation is only now beginning to be recognized by physicians. As yet it is viewed with complete disinterest by other groups in the community. It may be pointed out that there is a great difference between an ordinary negligence action and a malpractice action brought against a physician. In a malpractice action the character of the defendant, his personal integrity, is assailed —his professional reputation is injured by the mere filing of the action.

So common have malpractice accusations become that the very word, "malpractice," now brings to the mind of the average person the picture of a physician mistreating or neglecting his patient. So common have these claims become that, in this locality at any rate, whenever a bad result occurs, there is a strong tendency to blame the attending physician. If the patient does not himself think of blaming the doctor, some one usually suggests it to him.

Not only is the whole profession injured, but the public interest is deleteriously affected by this condition. A physician if he has had his malpractice eyes opened will give thought to safeguarding himself, while he is treating a patient, because an unjustifiable malpractice claim may eventuate from the case. And those of you who know anything about this subject know that, commonly, it is the most reputable among us who is attacked. This, perhaps, is on the theory that he who has most to lose can most easily be softened up to buy his peace.

HOW MALPRACTICE SUITS DESTROY PUBLIC'S CONFIDENCE IN PHYSICIANS

It is fundamental that confidence on the part of the patient toward his physician is a vital element in the physician-patient relationship. The patient's confidence in his physician distinctly contributes to his recovery. The unwholesome situation which the malpractice sore has created is breaking down the public's confidence in the profession. The public is gradually being sold the idea that protection against the profession is needed. This attitude is reflected, more and more frequently, in the attitude of jurors and in the verdicts rendered by juries.

In a recent case, considering the evidence in the record and the Court's instructions, the jury's failure to agree upon a verdict for the defendant was a tremendous surprise to all who had followed the case. It was illuminating, to hear dissenting jurors say that they did not believe any defense witness—this particularly in view of the fact that it would not be possible, in any case, to present witnesses of higher credibility.

A further indication of the unfortunate trend in malpractice, is seen in another case wherein the jury brought in a verdict for the plaintiff, the patient. The Court, in granting a motion for a new trial, said in substance that he could not find one iota of evidence in the record to sustain the jury's verdict.

TREND OF JUDGMENTS IN MALPRACTICE CASES IS AGAINST THE DEFENDANTS

Further evidencing that the trend in malpractice cases is against the defendant, it is pointed out that the doctrine of *Res Ipsa Loquitur* in its application to malpractice cases has been extended, and that the concept of common knowledge and observation has been widened. Apparently it is thought that a lay jury may be considered capable to differentiate between an eye, the sight of which was destroyed by a corrosive solution, and an eye blind as the result of infection. And it has recently been held that whether a tendon was severed or not was within common knowledge and observation, expert testimony being necessary. The "experts" on such a jury might very advantageously be medically employed.

THE LAW IN RESPECT TO COMPELLING DISCOVERY BEFORE TRIAL

As background to the next, and to my mind, the most important point I have to discuss, it is pointed out that the common law provided no means whereby a party to a law action could be compelled to disclose facts or to produce documents for the use of his opponent. On the premise that there was a failure of justice at common law, equity provided a remedy.[1] Bills of Discovery were made available to parties to actions to require disclosure by the defendant of facts, deeds, documents, or other things in his exclusive knowledge or possession which were necessary to the party seeking the discovery as a part of a cause or action pending. In many jurisdictions, statutes now exist which provide for the pre-trial examination of parties in actions at law.[2]

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* Read before Pasadena-Alhambra Branch of the Los Angeles County Medical Association, November 20, 1945.

From studying the development and the course of the law in respect to compelling discovery before trial, both in equity and under statute, the conclusion, in my opinion, is inescapable that only the disclosure of material facts was within the contemplation of the Courts or legislatures.

It is further pointed out that at common law a party to an action cannot be compelled to testify against himself. In many jurisdictions, under statue, a party to an action has the right to call the adverse party and to compel him to testify.

California Code of Civil Procedure, Sect. 2055, reads as follows, (in part):

> "A party to the record of any civil action or proceeding or person for whose immediate benefit such action or proceeding is prosecuted or defended (or the directors, officers, superintendent, or managing agent of any corporation which is a party to the record), may be examined by the adverse party as if under cross-examination, subject to those rules applicable to the examination of other witnesses."

Similar statutes exist in a number of states. The courts of several of these states have had occasion to construe these statues, to establish their meaning, application, and limitation. It is fair, I think; to say that characteristically it has been emphasized that the statute has application to *material facts.* One of the earliest of these cases was that of Langford v Issenhuth,[3] a 1912 South Dakota case. In that case the court constantly reiterates *fact, material fact.*

In most of the succeeding cases, in the several states, reference is made to the South Dakota case.

In Osborn v Carey,[4] a malpractice case, the Supreme Court of Idaho said the statute was not intended to enable an adverse party to call an opposing party as an expert. It is similarly held in an Ohio case—Forthofer v Arnold.[5]

In the month of April, 1944, two decisions came down which dealt with the point whether, under statute permitting the calling of the adverse party, the defendant physician in a malpractice action may be required to give expert testimony. A New Jersey court[6] held that the defendant may not be made an expert by the plaintiff. The California Supreme Court[7] held that he may be made a plaintiff's expert. Both courts quote from Langford v Issenhuth and, in part, seem to base their reasoning on the holding in that case. I cannot reconcile the divergent conclusions. The effect, insofar as we in California are concerned, is unfortunate.

LIMITATIONS PLACED UPON CROSS-EXAMINATIONS

In the ordinary examination of a witness, first by direct examination and then by cross-examination, there is under the general rule, some limitation placed upon the cross-examination; cross-examination must be kept within the scope of the direct examination. In People v Buzzel,[8] a California court said that it is elementary that cross-examination should not be permitted to go beyond the scope of the direct examination. But under a statute permitting the calling of the adverse party and examining him as if under cross-examination, there has been no direct examination to set a limiting standard; the scope of the examination is, to all practical purposes, unlimited. In Good v Brown (Cal.),[9] it was said that in view of C.C.P., Sect. 2055, which permits a litigant to call his adversary and subject him to cross-examination as to any relevant matter without waiting for a foundation to be laid by previous direct examination, the Court does not commit error in permitting a wide cross-examination of a defendant.

ON HYPOTHETICAL QUESTIONS

The medical expert witness may be, and usually is, asked hypothetical questions. Under the general rule, every fact which is assumed in the hypothetical question asked of the expert witness must have some evidence in the record to sustain it. Under a rule, permitting the defendant-physician in a malpractice case to be made an expert witness for the plaintiff when called as an adverse witness, not only is he subject to unlimited cross-examination not binding on the plaintiff, but in actual practice he is commonly asked hypothetical questions, the facts assumed having at that time no foundation whatever in the record and at times being actually contrary to the only available evidence.

It is very well to say that the defendant may prove to strike if matters are not connected up, if no evidence is forthcoming to support this or that fact among the many which have been assumed, but it is asking of a lay jury more than is humanly possible to suggest that the prejudicial effect be eliminated from their minds.

ON PRE-TRIAL DEPOSITIONS

The defendant-physician, called by the plaintiff under the statute, may be the first witness to testify at the trial. Moreover, upon pretrial deposition, he is asked opinion questions and, upon citation if such is necessary, required to answer them when there is, of course, no record at all upon which to found them. Plaintiffs are encouraged, under these circumstances, to file actions which have no merit and thereafter to exercise the opportunity which is provided them to go on "fishing expeditions." Equity Courts rightfully exercised care to see to it[10] that Bills of Discovery were not so used or misused.

It is submitted that in these circumstances the defendant-physician is placed under an unjust and impossible burden, and that further consideration of his present unenviable position is indicated. It is suggested that the best solution would be an amendment to the procedural statute to incorporate, in substance, that no witness may be required to give expert opinion testimony unless he has previously contracted to do so.

MALPRACTICE SUITS AS A PRESENT-DAY PLAGUE

I have tried to show that malpractice is a present day plague; that its effects are destructive; that because of it medical prestige is suffering and public confidence in the profession is breaking down; and that this condition is reflected in juries' verdicts and Court's decisions.

I have endeavored also to emphasize that the malpractice problem is our problem. It is distinctly up to the medical profession to solve this problem. Why should the physicians of this state go on being easy targets, sort of "sitting birds" for any sharpshooter who decides he has found an easy way to get some money or to get out of paying his bill?

COMMENT

No one has come forward to help us. Surely no intelligent person can criticize us for taking any action necessary for our self protection. Physicians would be unbelievably stupid to continue, blindly and supinely, to permit themselves to be publicly pilloried by unjust charges against reputation and character.

It will indeed be a grand day when our doctors cease to expect that some "Malpractice Santa Claus" is going to do this job, and finally decide to take any steps necessary to terminate this evil.

Suppose, for illustration, the doctors decide for the purpose of malpractice claims prevention that it is necessary to have an independent physician join the attending physician in the care of each and every patient, saving the most simple, and even in such a case unless recovery is immediate and perfect? Or three or four independent physicians? This procedure would solve the malpractice problem. Milder measures, universally adopted, might be sufficient. But, after twenty years of close observation and study in this field, I am convinced that no marked improvement may be anticipated or even hoped for until the organized group, and the individuals making it up, become fully aroused and act accordingly.

A POLICY OF OFFENSE, NOT OF DEFENSE, IS INDICATED

The rising tide of malpractice is engulfing us. It more than any other thing threatens to flood us into the sea of state medicine. We have until now been entirely on the defensive. We must assume an offensive attitude. Let us raise our voices in insistent demand that the governing bodies of our State and County Associations undertake a continuous, aggressive campaign to end the malpractice racket, and that any action necessary to bring about the desired result, be taken.

6777 Hollywood Boulevard.

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4. 132 Pac. 967.
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6. Hull v Plume (N. J.), 37 Atl. (2d) 53.
7. Lawless v Calaway (Cal.), 147 Pac. (2d) 604.
8. 104 Pac. (2d) 503.
9. 196 Pac. 299.
10. Yorkshire Worsted Mills v National Transit Co. (Pa.), 190 Atl. 897; Midwest Mfg. Co. v Staynew Filter Corp., 12 Fed. Supp. 876; Colvocoresses v W. S. Wasserman Co. (Del.), 13 Atl. 439; Peyton v Wehane (Conn.), 11 Atl. (2d) 800.

Navy Commends U. C. Medical School

A letter of commendation from the Navy Department to the University of California Medical School for playing "a significant part" in training doctors for the Medical Corps under the V-12 Program has been received by Dr. Francis S. Smyth, dean of the school.

Signed by Vice Admiral Louis Denfield, chief of naval personnel, the letter states in part:

"The whole-hearted coöperation of your administration, the excellence of your facilities and the skill of your instructional staff helped make possible an immense expansion which, because of the efforts of medical colleges, saw no lowering of professional standards.

"The defeat of Japan has now made it possible for the Navy Department to discontinue its medical training program and for medical colleges to return to the education of doctors for civilian practice.

"May I assure you that it is with mingled regret and pride that the Navy Department leaves the scene of medical education; regret that our association has ended and pride in the knowledge of a mission accomplished."

HEPARIN AND DICUMAROL—ANTI-COAGULANTS*

THEIR PROPHYLACTIC AND THERAPEUTIC USES

Paul M. Aggeler, M. D.
San Francisco

The brilliant studies of Best and his associates[1] at the University of Toronto, and of Link and his coworkers[2] at the University of Wisconsin have made available for clinical use two potent anti-coagulant drugs, heparin and dicumarol** for the prophylaxis and treatment of thrombosis and embolism. It is the purpose of this communication to discuss the physiological basis of anti-coagulant therapy, the indications for the use of the anti-coagulant drugs and their methods of administration, and the hemorrhagic complications which may follow their use.

Anti-coagulant therapy has not been used in a sufficient number of cases to allow a comparison of the results with those of other methods of treatment such as lumbar sympathetic block, proximal venous ligation and early ambulation. All that can be said at the present time is that the anti-coagulants appear to be effective remedies. The evaluation of the relative merits of the various forms of therapy must await further study.

THE PHYSIOLOGICAL BASIS OF ANTI-COAGULANT THERAPY

There is a close relationship between thrombus formation and blood coagulation although the two processes are not identical. In the process of blood coagulation the platelets disintegrate and thereby yield thromboplastin. The release of this substance leads ultimately to the formation of a clot, composed of all of the cellular elements of the blood enmeshed in interlacing strands of fibrin. In the formation of a thrombus, the function of the platelets is to agglutinate on the endothelial surface of the blood vessel at the site of injury. Under varying conditions three types of thrombi may be formed: the "white" thrombus, composed entirely of agglutinated platelets, the "red" thrombus, which is similar to an ordinary blood clot, and the "mixed" thrombus which contains lamellae of platelet masses and coagulated blood. All substances which inhibit coagulation of the blood also prevent agglutination of the platelets. The use of anti-coagulants to prevent thrombus formation is therefore a rational procedure, regardless of the type of thrombus which may be formed.

In the evolution of a white thrombus, the agglutinated platelets become hyalinized and much of the fluid content of the thrombus is resorbed. Organization takes place through ingrowth of cells from the lining of the blood vessel.

When a white or mixed thrombus completely occludes a vessel, a red thrombus forms in the channel proximal to it, where the blood has ceased to flow. Such thrombi usually become firmly attached to the vessel wall and rarely lead to embolus formation. However, a thrombus may propagate without completely occluding the lumen of a vein and may float in the passing blood stream with few or no attachments to the vascular endothelium except at its point of origin. Detachment, in whole or in part, of such thrombi gives rise to the vast majority of pulmonary emboli. Anti-coagulant therapy, properly administered, will aid in the prevention of embolization by limiting the further extension of thrombi and by allowing time for the natural process of organization to take place. It must be emphasized, however, that no anti-coagulant will dissolve a thrombus which has already formed.

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* Read before the Section on General Medicine, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

From the Department of Preventive Medicine, University of California, San Francisco Campus.

** Dicumarol is the collective trademark of the Wisconsin Alumni Research Foundation, which controls the use thereof.

INDICATIONS FOR THE ADMINISTRATION OF ANTI-COAGULANTS

Heparin alone, or in combination with dicumarol, has been used successfully in vascular surgery to prevent the formation of thrombi at the operative site. There have also been many reports of the use of these anti-coagulants for the prevention of thrombo-embolic complications following major surgical operations. Both drugs have proved effective in the treatment of thrombophlebitis, mesenteric thrombosis, massive pulmonary embolism, and thrombosis of the central retinal vein. They have both been used, with little success, in the treatment of cerebral and coronary thrombosis, and in various occlusive peripheral vascular diseases. Heparin and dicumarol, in conjunction with penicillin or the sulfonamides, have both been used successfully in the treatment of cavernous sinus thrombosis, but they have been of doubtful value in the treatment of subacute bacterial endocarditis.

The administration of heparin can be commenced within four hours after operation without danger of hemorrhage from the wound. Dicumarol can be started on the day of operation. The duration of administration of either drug varies with the indication for its use. In vascular surgery a period of three to five days is usually sufficient. For prophylaxis following general surgical procedures, treatment has usually been given for five to ten days, although many prefer to continue treatment until the patient is ambulatory. In the treatment of thrombophlebitis the anti-coagulants should be continued until the local signs of inflammation have subsided and the temperature, pulse, sedimentation rate and leukocyte count have returned to normal for approximately one week.

If adequate dosage of the anti-coagulants could be given with ease and safety, and at little expense, it would be advantageous to administer them to all patients after major surgical procedures. However, there are many deterrents to their widespread administration and their prophylactic use has generally been limited to conditions where a relatively high incidence of thrombo-embolic complications can be expected to occur. The patients best suited for the prophylactic use of the anti-coagulants are those who have suffered from thrombophlebitis or pulmonary embolism following the current or previous operation, those undergoing certain types of operations, such as abdominal hysterectomy or splenectomy and those who suffer from heart disease, varicose veins, obesity, anemia, senility or malignant neoplastic disease.

LABORATORY PROCEDURES FOR THE CONTROL OF ANTI-COAGULANT THERAPY

The determination of the venous blood coagulation time and the prothrombin concentration are the tools without which heparin and dicumarol cannot be properly administered. It is the unfortunate impression of most physicians that blood coagulation tests give results that are as reliable as blood counts or other hematologic procedures. This is not true. There are many more sources of error in coagulation tests than in other common laboratory techniques.

The Venous Blood Coagulation Time:

The following are some simple precautions which will give greater reliability to the results of this test:

1. Always use the same size needle (preferably 20 gauge) and the same size syringe (10 to 20 cc.)

2. The syringe should be either perfectly dry, or rinsed with physiological saline, or lined with vaseline or mineral oil.

3. The tip of the syringe must not be chipped. Bubbling of air through the blood will cause marked shortening of the coagulation time.

4. Don't jab for a vein. Unless it can be entered cleanly on the first attempt, tissue juices which shorten the coagulation time will accumulate in the barrel of the needle and cause great shortening of the coagulation time.

5. Let the blood run gently from the syringe down the inside of the test tube. Do not squirt the blood.

6. Use the same size tube for all tests. The larger the tube, the longer the coagulation time will be. The tubes should be either perfectly dry or freshly rinsed with physiological saline.

7. Tip the tube at regular intervals. Try to avoid dislodging an incipient clot.

8. Do the test in duplicate or triplicate and average the results.

9. Whenever possible do the test at 37° C. It is not necessary to have an expensive waterbath. A thermos bottle containing water at 37° C. is perfectly satisfactory.

10. *Do not rely on normal standards published in text books.* Each technician should be required to produce proof of his own standards of normality.

The Prothrombin Determination:

The Quick method,[3] or one of its numerous modifications, appears to be the most satisfactory procedure for routine clinical use. It is a simple test in the hands of one properly trained in its performance, but the results are most unreliable unless precise technique is employed. The test is based on the theory of blood coagulation which proposes that thromboplastin, in the presence of calcium, converts prothrombin to thrombin, which in turn converts fibrinogen to fibrin, the strands of which are the end results of clotting. With rare exceptions the variations in calcium and fibrinogen encountered in man do not affect the blood coagulation time. Therefore, the speed of the clotting reaction, after the addition of an excess of thromboplastin, is used as a measure of the amount of prothrombin present. The standard of reference is the time required for the reaction to take place in the normal subject. It is necessary to have standards to which the results of every investigator can be referred. The use of the prothrombin time itself is unsatisfactory, because the time depends upon the potency of the thromboplastin solutions employed. For this reason the conversion of the prothrombin time to prothrombin concentration was originally suggested by Quick. In order to do this the prothrombin times of appropriate dilutions of normal plasma are plotted on a graph. A line drawn through the points so obtained will form a parabolic curve such as is shown in Chart 1. Reading from such a curve the prothrombin time of an unknown specimen can be converted to prothrombin concentration. Because of technical variations and of actual differences in the prothrombin concentration of different normal individuals, it is necessary to do the test on a series of plasma dilutions from at least five normal subjects, using the same specimen of thromboplastin for each, in order to establish a reliable standard curve.

The use of the prothrombin index or the "prothrombin time per cent" as it is called by some authors can be dangerously misleading. This value is obtained by dividing the normal prothrombin time by the patient's

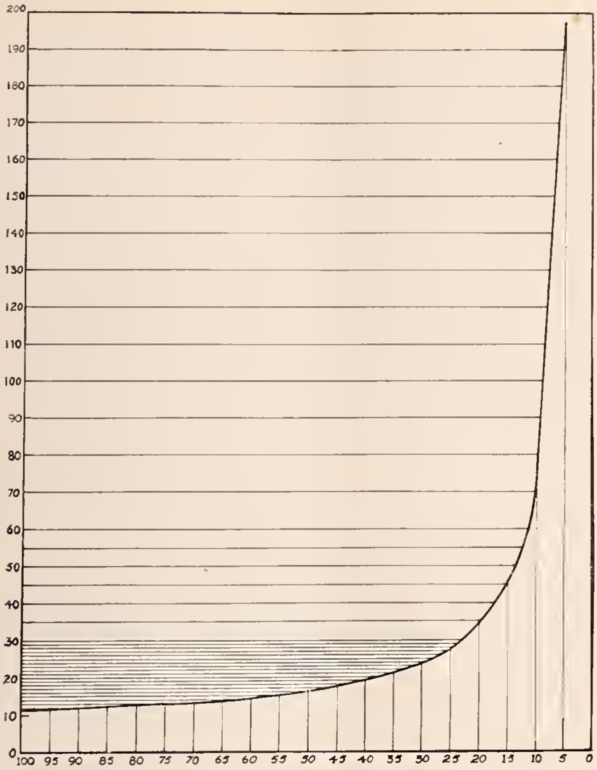

Chart 1.—Graph used for the conversion of prothrombin time to prothrombin concentration.

(In above chart the numbers in the vertical column represent the Coagulation Time in seconds.
The numbers in the horizontal column at the base of the Chart represent the Prothrombin Concentration, in per cent of mean normal.)

prothrombin time and multiplying by 100. In Table 1 the prothrombin times obtained by various authors using different specimens of thromboplastin have been converted to prothrombin indices. The results show that the values for the prothrombin index are always higher than their respective prothrombin concentrations. A prothrombin index of 70 may correspond to a prothrombin concentration of 30 per cent and a prothrombin index of 30 may correspond to a prothrombin concentration of 5 per cent.

The best source of thromboplastin for the prothrombin test is dehydrated rabbit brain, but the preparation and proper standardization of this material is too time-consuming for most laboratories doing routine clinical work. The use of commercially available thromboplastin for the test is not entirely satisfactory at the present time. Many of the products are not sufficiently active, the material in different ampoules varies in potency, and the quantity dispensed is too small for proper standardization. It would be a real contribution toward the solution of this problem if commercial distributors would market sets containing a sufficient number of ampoules of dehydrated rabbit brain of the same potency so that the material could be individually standardized in each laboratory which proposed to use it.

HEPARIN

Chemistry:

Heparin is a strongly acidic compound of carbohydrate nature. Its chemical formula is thought to be similar to the proposed formula of mucoitin poly-sulphuric acid. It contains glucosamine, an unknown uronic acid, and sulphuric acid in ester linkage. It has been crystallized as the barium salt from various tissues of different animal species. The commercial preparation is made from beef lung. All products which are available for clinical use* are dispensed in 10 cc. vials each containing 10 mg. of heparin per cc.

Mode of Action:

Heparin forms stable salts with many proteins on the acid side of the iso-electric point. When heparin is added to blood, it will unite with the various plasma proteins. The combination of heparin and a fraction of the plasma albumin produces a substance which is able to neutralize thrombin and which is therefore a powerful anti-coagulant.

Prevention of Experimental Thrombosis:

The classical studies of Best and his associates at the University of Toronto have provided ample experimental proof of the ability of heparin to prevent platelet agglutination and thrombus formation. In experiments performed on dogs the formation of thrombi on the intimal surface of veins, which were injured by mechani-

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* Heparin—Lederle, Lilly, Abbott.
Liquemin—Roche Organon.
Solution of Heparin—Connaught Laboratories, Toronto.

Table 1.—*Comparison of the Prothrombin Time, Prothrombin Concentration and Prothrombin Index Obtained With Different Specimens of Thromboplastin*

Prothrombin Time					Prothrombin Concentration*	Prothrombin Index**				
No. 1	No. 2	No. 3	No. 4	No. 5		No. 1	No. 2	No. 3	No. 4	No. 5
10	11½	12	19	27	100%	100	100	100	100	100
17½	24	18	27		30%	57	49	67	70	
21	35	21	35		20%	48	33	57	54	
37	75	35	60	60	10%	27	15	34	32	45
97	197	69	118	90	5%	10	6	17	16	30

No. 1—Pohle, F. J., and Stewart, J. K.: Am. J. Med. Sci., 198, 622, 1939.
No. 2—Aggeler, P. M., and Lucia, S. P.: Unpublished data.
Nos. 3 and 4—Hurn, M., Barker, N. W., and Magath, T. B.: Proc. Staff Meet., Mayo Clin., 19:507, 1944.
No. 5—Davidson, C. S., and MacDonald, H.: Am. J. Med. Sci., 205, 24, 1943.
* Obtained by plasma dilution.
** Prothrombin index (Prothrombin time per cent) $= \frac{\text{Undiluted plasma prothrombin time} \times 100}{\text{Diluted plasma prothrombin time}}$

cal or chemical means, was prevented by the continuous intravenous administration of heparin.[4] In another series of experiments performed on dogs, cats and monkeys, in which a glass cell (with a transverse scratch on its inner surface) was connected between the carotid artery and the jugular vein, the agglutination of platelets was inhibited or prevented by the administration of large amounts of heparin.[5]

Clinical Administration:

In vascular surgery heparin has been used locally and regionally but in recent years these methods have been supplanted by general heparinization.

Intravenous administration is the method of choice with the heparin products now available for clinical use. Because its effect in vivo is rapidly lost, it must be given either by continuous intravenous drip or by frequent intravenous injections. In the average subject the injection of 10 mg. (1 cc.) of heparin will produce only a slight prolongation of the coagulation time, and its effect will be lost within one hour. Increasing doses of the drug up to 40 mg. (4 cc.) will produce progressively greater prolongation of the coagulation time to approximately one hour and the effect of the drug will gradually be lost over a period of about 4 hours. With larger amounts of heparin the coagulation time will be immediately prolonged to a greater degree, but the duration of effect will not be significantly prolonged.[6]

Satisfactory results have not been obtained following intramuscular and subcutaneous administration of aqueous solutions of heparin. However, the recent work of Loewe and Rosenblatt[7] with heparin in a gelatin base, and of Bryson and Code[8] with heparin in a beeswax mixture, suggests that a single subcutaneous injection of a large quantity of the drug will produce a satisfactory prolongation of the coagulation time for a number of days. The necessity for less frequent injection of the drug by this method is an advantage over the intravenous route of administration, but its prolonged action may prove to be disadvantageous if hemorrhagic complications occur.

The Toronto group found in the experimental animal that it was not necessary to render the blood completely incoagulable in order to prevent the formation of thrombi and they suggested that for clinical use the dosage of heparin should be adjusted so that, when given by continuous intravenous drip, the coagulation time of the patient would be maintained at approximately twice its normal value. It appears from the literature, however, that dosage of heparin sufficient to maintain a prolongation of the coagulation time as high as 4 or 5 times its normal value has frequently been employed. This may account for a higher incidence of hemorrhagic complications than would have been found if a smaller amount of the drug had been administered.

When the continuous intravenous drip technique is used, it is customary to mix the desired amount of heparin in physiological saline or 5 per cent glucose solution. The total amount of solution can be varied to meet the requirements of the patient, but for convenience in calculation 100 cc. per hour is usually employed. The effect of the same dose of heparin on the coagulation time of different subjects is variable and must be determined in each patient by frequent tests of the venous blood coagulation time. A dose of 10 to 30 mg. (1 to 3 cc.) per hour is usually given. An initial "priming" dose of 20 to 30 mg. (2 to 3 cc.) is sometimes employed. The continuous intravenous administration of fluids at a constant rate is a difficult procedure. The rate of flow may vary appreciably, depending upon changes in the posture of the patient, the height of the column of fluid being administered and other factors; and must be checked at frequent intervals. Phlebitis or clogging of the needle rarely occurs when heparin is being administered. For greater comfort to the patient it is desirable to use a vein in the leg or in the forearm rather than one in the antecubital fossa.

Because of the disadvantages of continuous intravenous administration, heparin is frequently given by multiple intravenous injections. It is usually necessary to give 20 to 40 mg. (2 to 4 cc.) at 2 to 4 hour intervals. The exact dosage required must be determined for each patient. It is the aim of this method of administration to prevent the coagulation time from becoming at any time shorter than twice its normal value. Obviously in order to accomplish this result the coagulation time immediately after an injection of heparin must be greatly in excess of that required to prevent thrombosis.

Toxicity and Complications:

The products now available for clinical use are completely free of any toxic effects. The only danger of heparin therapy lies in its hemorrhagic complications, which include hematoma of the wound, gross hematuria and cerebral hemorrhage. The rate of hemorrhagic complications has varied from 0 to over 12 per cent in different reports,[9, 10, 11] but in general would appear to be about 1 per cent. Death due to the administration of heparin has been reported, but is very infrequent.

Treatment of Hemorrhagic Complications:

Usually all that need be done if bleeding occurs in the course of heparin therapy is to discontinue administration of the drug. When this is done the coagulation time of the blood will return to normal within a few hours. Blood transfusion will not counteract the anti-coagulant effect of heparin but may be required for treatment of shock of anemia due to blood loss.

Heparin, which is a highly acidic compound, is effective as an anti-coagulant by virtue of its combination with a fraction of the plasma albumin. When a strongly basic protein such as protamine is added to heparinized blood, the effect of heparin is immediately lost because the resulting protamine-heparin mixture does not possess anti-coagulant properties. Protamine has been administered intravenously to man without untoward effects,[12] but since it has not received extended clinical trial, its use as an antidote for heparin cannot be recommended at the present time.

Cost of Therapy:

The price of heparin is approximately $3.50 per 10 cc. amopule. Since it will require 24 cc. to 72 cc. per day to achieve adequate heparinization, the cost to the patient for heparin alone will be from $10.00 to $25.00 per day. To this must be added the cost of intravenous fluids, laboratory procedures and special nursing care, not to mention the physician's fee. The cost of heparin therapy is obviously prohibitive for most patients.

DICUMAROL

Chemistry:

Dicumarol 3, 3′ Methylene-Bis-(4-Hydroxycoumarin) is the responsible agent for a disease of cattle caused by spoiled sweet clover hay. It was isolated, identified and synthesized by Link and his co-workers.[1] It is a colorless, crystalline solid, which is relatively insoluble in water.

Mode of Action:

Dicumarol is rapidly absorbed from the gastro-intestinal tract, and following its administration the plasma prothrombin concentration is reduced. Its exact mode of action is not known, but it is presumed that it interferes with the elaboration of prothrombin by the liver.

Following the administration of dicumarol there is an initial delay of 24 to 48 hours before reduction of the prothrombin concentration is apparent. The maximum lowering of the prothrombin concentration occurs three to five days after dicumarol is first administered and a period of 5 to 11 days is usually required after the drug is withdrawn before the prothrombin concentration returns to its previous level.

Prevention of Experimental Thrombosis:

In all of the studies in which thrombus formation in experimental animals has been prevented by the administration of dicumarol, the drug has been given in sufficient dosage to cause a significant prolongation of the coagulation time and a marked reduction in the prothrombin concentration. Dale and Jaques[13] at the University of Toronto repeated with dicumarol the experiments previously done with heparin in their laboratory. In experiments on dogs, 60 per cent of the dicumarol-treated animals did not develop thrombi after the veins had been injured by crushing. The prothrombin time in these animals was maintained at over 200 seconds as compared with a normal time of 20 seconds. Although the prothrombin concentration in these animals is not given it must have been below 10 per cent of normal and may have been as low as 5 per cent. In the 40 per cent of animals in which thrombi formed, the prothrombin time had been maintained at 100 seconds. In a second series of experiments on dogs using a glass cell connected between the carotid artery and jugular vein, the agglutination of platelets was inhibited or prevented by the administration of dicumarol. In most of the animals the prothrombin concentration was maintained at a level of less than 5 per cent of normal. In the experiments on dogs done by Richards and Cortell[14] in which the veins were injured with ethanolamine oleate (Monolate, Abbott) the formation of thrombi was prevented by the administration of dicumarol. The level to which the prothrombin concentration was reduced cannot be determined from their report, but the fact that all four animals died of anemia due to hemorrhage a few days after the experiments were performed suggests that it was extremely low.

Because of the differences between the normal prothrombin concentration of dog and man, the level to which the prothrombin must be lowered in the dog to achieve satisfactory results need not necessarily be the same in man. However, there appears to be no experimental proof that thrombosis will be prevented in any species unless the coagulation time of venous blood is significantly prolonged.

Clinical Administration:

The disodium salt of dicumarol has been given intravenously in dosage of 4 mg./Kg every three to five days,[15] but the oral route of administration has been preferred by most investigators. Bingham, et al,[15] recommend dosage based on body weight (5 mg./Kg on the first day, and 1.5 mg./Kg daily thereafter, depending upon the prothrombin concentration), but in most studies the dose has been regulated entirely by the results of the prothrombin test. The initial dose has varied between 200 and 500 mg. and a dose of 100 to 300 mg. has frequently been given on the 2nd day. All investigators agree that after the second day the dosage must be regulated by the results of the prothrombin test. A review of a group of reports[15-23] in which the drug has been used clinically for the prevention or treatment of thrombo-embolic phenomena shows that when the *prothrombin concentration* has been carefully titrated a reduction to a level of 10 per cent to 30 per cent of normal provided the maximum therapeutic effect with a minimum of hemorrhagic complications. The prothrombin concentration should not be confused with the prothrombin index or the "prothrombin time per cent" as it is often called. In one report[23] a prothrombin time of 60 to 75 per cent was stated to have produced satisfactory results, and in another study[15] the danger of hemorrhage when the prothrombin time fell below 25 per cent was stressed. In view of the findings given in Table 1, it is probable that the time value of 60 per cent corresponded to a prothrombin concentration in the region of 30 per cent and that the time value of 25 per cent corresponded to a prothrombin concentration of less than 10 per cent.

The amount of the drug required to maintain the prothrombin concentration at a satisfactory level has been quite variable. The plan used at the Mayo Clinic[19] appears to be satisfactory: "The first day 300 mg. are given and 200 mg. are given on the second day. Two hundred milligrams are given on each succeeding day that the prothrombin is greater than 20 per cent of normal. If it is less than 20 per cent of normal no dicumarol is given on that day. Exceptions are occasionally made as follows: If the prothrombin is dropping rapidly but is still slightly greater than 20 per cent, no drug is given. If it is rising rapidly, but has not quite reached 20 per cent, a dose is given on that day. In the occasional patient who is found to be quite hypersensitive to the drug, it may be advisable to reduce some or all of the doses to 100 mg. In the occasional case of resistance, it may be advisable to increase them to 300 mg. For patients who have never had thrombosis or embolism and to whom the drug is given purely for prophylaxis, it may be advisable to omit the dose on the second day in order to be sure that the patient is not hypersensitive."

The degree of reduction of the prothrombin concentration required to produce a significant prolongation of the venous blood coagulation time has not been carefully studied in man. However it appears that in the average patient the prothrombin concentration must be reduced to a level of 20 per cent before the coagulation time is altered, and it must be reduced to approximately 5 per cent before the coagulation time is prolonged to more than twice its normal value. On the basis of animal expreimentation one would expect that the prothrombin concentration would have to be reduced to less than 5 per cent in order to prevent the formation of thrombi. But the maintenance of this level of prothrombin for a period of days in man is dangerous. The recommended therapeutic level of 20 per cent of normal therefore represents a compromise which may prove satisfactory because at this level the majority of patients can be expected to have some lengthening of the coagulation time.

Toxicity and Complication:

No toxic effects on the blood constituents or upon the organs or tissues have been found in man or experimental animals following dicumarol therapy. However, the studies of Bingham, Meyer and Pohle[24] in dogs receiving fatal doses of dicumarol showed that although no lesions were demonstrable in the blood vessels, there was widespread vascular dilatation in all of the viscera.

The types of bleeding which have occurred during dicumarol therapy include purpura, hematomata, bleeding into wounds, hemoptysis, gastroitestinal hemorrhage, hematuria, gingival bleeding, conjunctival hemorrhage and bleeding from unrelated ulcerative lesions.

The average rate of hemorrhagic complications in a number of studies was 8.3 per cent (Table 2). Even allowing for the fact that many instances of minor bleeding, such as microscopic hematuria, are included in this figure, it is still more than would be expected from the use of heparin under similar circumstances. However, there is reason to believe that in future studies the in-

TABLE 2.—*The Incidence of Hemorrhagic Complications Following Dicumarol Therapy*

Reference	Number of Patients Treated	Hemorrhagic Complications Number of Patients	Hemorrhagic Complications Per cent of Patients Treated	Deaths due to Dicumarol Number of Patients	Deaths due to Dicumarol Per cent of Patients Treated
Bingham, Meyer and Howard Am. J. Med. Sci., 205, 587, 1943	105	18	17.1*	0	0
Rhoads, Walker, and Panzer Northwest Med., 42, 182, 1943	21	2	9.5	0	0
Gefter, Kramer, and Reinhold Amer. Heart Jour., 28, 321, 1944	30	5	16.6	0	0
Wassermann and Stats Am. J. Med. Sci., 206, 466, 1943	71	8	11.2	1	1.4
Barker, Cromer, Hurn, and Waugh Surgery, 17, 207, 1945	1,000	64	6.4**	1	0.1
Zucker J.A.M.A., 124, 217, 1944	18	3***	16.6	0	0
Butsch and Stewart J.A.M.A., 120, 1025, 1942	150	7	4.7	1	0.7
Prandoni and Wright Bull. N. Y. Acad. Med., 18, 433, 1942	20	8	40.0	0	0
Evans N. Engl. J. Med., 230, 131, 1944	56	8	14.3	2	3.6
Totals	1,471	123	8.3	5	0.34

* Including 15 per cent with microscopic hematuria.

** 3.9 per cent described as minor bleeding, including epistaxis, microscopic hematuria and slight oozing from wounds.

*** Including two instances of microscopic hematuria.

cidence of hemorrhagic complications can be materially reduced by better selection of patients and more careful regulation of dosage. Most of the hemorrhagic complications have occurred in patients whose prothrombin concentrations were maintained at less than 10 per cent for a prolonged period of time. The lowest incidence of hemorrhage has been in those patients who already suffered from thrombo-embolic phenomena and the highest incidence has been found when the drug was used as prophylaxis against the formation of thrombi in patients who had granulating or ulcerating surfaces from which bleeding could readily occur.

Dicumarol is contraindicated in patients who suffer from diseases of the liver or kidney or from any type of hemorrhagic disease.

TREATMENT OF HEMORRHAGIC COMPLICATIONS

The hemorrhagic complications of dicumarol therapy can usually be controlled by repeated fresh whole blood transfusions and massive doses of vitamin K. However, the reports of various investigators indicate that the transfusion of fresh whole blood is not an entirely reliable means of treating the hemorrhagic complications. When the prothrombin concentration is greatly reduced the immediate effect of transfusion is to elevate the prothrombin concentration approximately 5 per cent. However, the effect of transfusion may be transitory because of the continuing action of the dicumarol.

Synthetic vitamin K compounds have been found effective as an antidote for dicumarol only when used in very large doses.[19, 25, 26] Several of the commercial distributors are now marketing menadione in 60 mg. ampoules for the treatment of the hemorrhagic complications of dicumarol therapy. It is recommended that the entire dose be repeated at eight hour intervals until the bleeding ceases. Unfortunately even though the prothrombin concentration may be elevated following its use, the bleeding may continue for as long as 24 hours.

COST OF THERAPY

The cost of dicumarol is slightly over 3 cents per 100 mg. capsule. A comparable dose of dicumarol is therefore about 1/100 as expensive as heparin. Since it is given orally no intravenous fluids or special nursing care is required. The only additional expense is that required for a daily prothrombin determination.

COMBINED TREATMENT WITH HEPARIN AND DICUMAROL

In conditions where an immediate anti-coagulant effect is required, it is necessary to begin treatment with heparin. The administration of dicumarol can be commenced at the same time, and as soon as the prothrombin concentration has reached the desired level the heparin may be discontinued.

Rhoads, et al,[16] have suggested another method of combined treatment. The dose of dicumarol is adjusted so that only a moderate reduction in the prothrombin concentration, not sufficient in itself to prolong the venous blood coagulation time, is maintained. When the prothrombin concentration is reduced in this manner, a 5 cc. injection of heparin given at 8 to 12 hour intervals is sufficient to maintain a marked reduction in the coagulation time. The advantages of this form of treatment are that much less heparin is required, and that it can be given intramuscularly, thereby reducing the cost and dispensing with the need for continuous intravenous infusion. Furthermore, discontinuance of the heparin should suffice to restore the normal blood coagulation time and rapidly control any hemorrhage which might occur.

SUMMARY

In sufficient dosage the anti-coagulant drugs, heparin and dicumarol will effectively prevent the formation of thrombi. They will not dissolve clots already formed, but will limit their further extension and will aid in the prevention of embolization from such thrombi. The danger of hemorrhagic complications limits the usefulness of these drugs.

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VOLVULUS OF THE CECUM—WITH LEFT SIDED COLON

REPORT OF CASE

J. H. Brady, M. D.

Visalia

FROM a purely anatomical standpoint, there are few conditions more interesting than non-rotation of the bowel. From the surgeon's viewpoint, even more interest is attached to such congenital malformations, when the surgical possibilities of such conditions must be kept in mind and acted upon in emergencies. The presentation of this article is therefore with two objects in mind, to review some of the anatomical possibilities of non-rotation and mal-rotation, as well as fixation of the bowel, and to make observations regarding the surgical care indicated, when emergencies such as volvulus occur, requiring immediate operative procedure for relief.

COMMENT ON LITERATURE

McGregor[1] has divided rotation of the mid-gut into three stages, embryologically. He states that volvulus of the ileo-cecal segment is the typical lesion in later life resulting from imperfect rotation or deficient fixation of the gut. In our case, both of these latter deficiencies were present, the volvulus being directly related to two factors, the incomplete rotation, which stopped during McGregor's late second stage, thus leaving the cecum in the left hypochondrium, and the unusual mobility of the proximal colon due to deficient fixation of that portion of the mesentery distal to the superior mesenteric artery.

Wolfer,[2] et al (1942) have presented an interesting classification of various defects in rotation and fixation, which conditions were observed in the dissecting room, and also were seen at the time of operation. The case to be presented falls into Wolfer's group VI, that is the group which has a common ileo-cecocolic mesentery, with complete freedom of the right colon. This case was similar to other conditions described in literature, but was not a true twisting of bowel about itself as an axis. Rather, it was a condition of looping of the bowel, much as a child in a swing would cause the swing to become looped by rotating himself and the swing about a vertical axis. In the case to be described, this looping involved the entire ileum, cecum, and ascending colon, the direction of the twist being clockwise, about the superior mesenteric artery as an axis, when viewed from below and anterior. The extent of this twist was approximately 270°. Other similar cases have been reported by Corner and Sargent[8] (1905). Rixford (1920), Carter[9] (1938), and Low and Hilderman (1940). Other reports in literature have given classifications, namely Treves (1900), Corner and Sargent (1905), Faltin (1902) and McGowan and Dixon (1936), but these classifications do not particularly aid in determining the proper procedure to carry out when surgical crisis occurs. Wolfer, et al, again have presented the sound philosophy which has always been true, that sound surgical judgment is of more importance than any detailed classification.

Statistical study of various groups of cases has revealed that 70 per cent of all cases of volvulus of the cecum occur in males. Etiological factors, other than congenital malformations have been mentioned by Beeger, namely lifting, excessive eating, violent exercise following meals, and pregnancy. Among the interesting case reports in recent literature were those of Graham[5] (1926), in which the volvulus occurred during a case of typhoid fever; Rose's[3] report (1941) in which the volvulus was associated with puerperal endometritis and gangrenous vulvitis, thus making preoperative diagnosis almost impossible; Morris'[4] case (1941) in which volvulus of the cecum occurred during pregnancy, was diagnosed by x-ray studies, and successfully treated, even to preservation of the pregnancy; Nelson's[6] case (1928) in which the volvulus occurred ten days postoperatively; and Kirby's[7] case (1929) in which resection and anastomosis three days after occurrence of the volvulus, resulted in recovery.

The principles for treatment are of prime importance to the surgeon. Bundshuh (1913), in giving his principles of treatment condemns any immediate enterostomy, or cecostomy, presenting figures which showed no recoveries from such cases. However, the temporary recovery in the patient here reported, and following such a procedure, would seem to contradict his statements in some degree.

REPORT OF CASE

Case 1.—Name: T. C., white male, age 17 years, admitted to Tulare County Hospital as an emergency case about 5 P.M., May 28, 1942. He stated that he had been acutely ill with sudden onset, since 4 P.M., May 27, 1942, with intestinal cramps, no bowel movements, no passage of blood, or mucus. His abdomen had become more and more distended the night of the 27th and especially so on the day of admission, and the cramps had not subsided even after several doses of an opiate administered hypodermically. He had vomited shortly after the onset, and this had continued intermittently, as had his cramps, until, at the time of admission the vomiting had become fecal in character.

Past History.—Development had been normal during early infancy, but during childhood, until the time of ad-

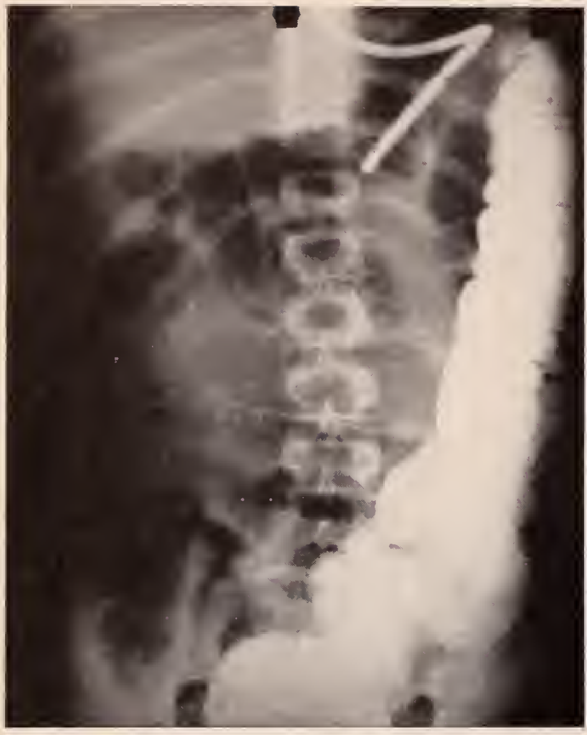

Fig. 1.—Antero-posterior x-ray after barium enema. Note left-sided colon.

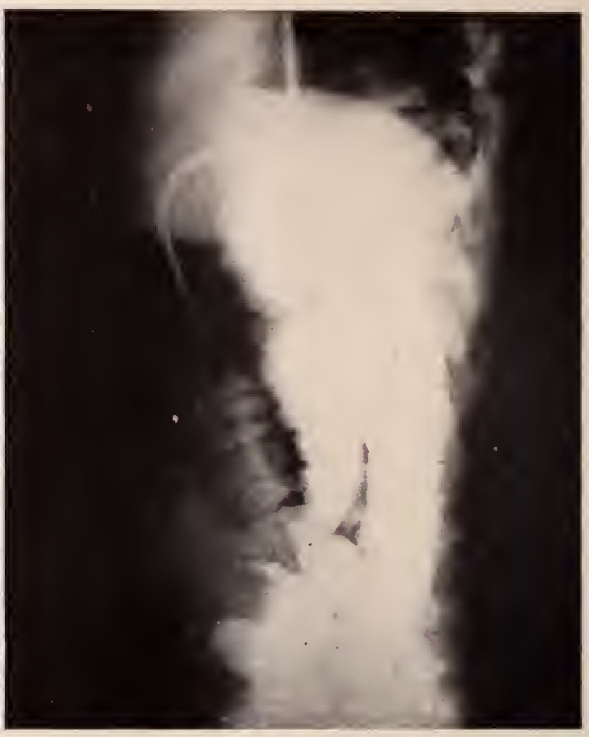

Fig. 2.—Lateral x-ray after barium enema. Note three different loops of colon in three different saggital planes.

mission, there had been several attacks of cramps, vomiting, and diarrhea, the last attack prior to the present illness occurring one year prior to hospital admission. There had been no previous operations.

Physical Examination.—(On admission.) Acutely ill white male of about stated age, with easily apparent abdominal distention. On observation he appeared to have intermittent attacks of pain in his abdomen. Temperature—99.6, pulse—88, respirations—22. Blood pressure—124/74. Eyes, ears, nose and throat: negative.

General Examination.—This was essentially normal except for the abdomen which was distended, tympanitic, with borborygmus, and metallic tinkling. There was tenderness over the entire abdomen, no masses were felt abdominally or rectally. Blood count: Hemoglobin—108 per cent; R.B.C.—6.05 million; W.B.C., 28,300; N—91 per cent; L—9 per cent. Urine: One plus albumin. Very faint trace of sugar, loaded with hyaline and granular casts, 25-35 pus cells, few blood cells. Enemas were administered in an attempt to reduce a suspected intussusception, hut there was no resulting stool, blood or mucus.

Barium Enema: This examination was done following the administration of enemas mentioned above. The resulting pictures are shown as Figs. 1 and 2, the striking finding being the absence of a transverse colon in its proper relationship, the lateral view giving the explanation since here a second loop of colon lay anterior and parallel to the descending colon, and a third loop was seen anterior to this second loop. None of the colon was seen on the right side of the abdomen, yet it filled readily for 2/3 of its length. There was a marked generalized gaseous distention seen.

Surgery.—Operation performed May 28, 1942, under spinal anesthesia of pontocaine and procaine, consisting of the following:

Para-umbilical, para-median incision eight inches long was made. On incising the peritoneum approximately 1,750 cc. of blood-tinged, serous fluid was aspirated. The cecum immediately presented in the wound (to the left of the umbilicus and very high). It was dilated to about four inches in diameter, and was of a dusky, brownish color, with dark greenish areas present, each measuring 2 cm. in diameter. The appendix and the entire ileum, as well as the entire ascending colon, or what would have been the ascending colon, if properly placed, were dilated in proportion and of a similar color. On following down the loop of intestine so involved, a very long mesentery was discovered which appeared to be a continuous ileocecocolic mesentery, with very narrow base. The entire loop described above had twisted clockwise (viewed from in front and below the patient) having as its axis, apparently, the superior mesenteric vessels, the volvulus being 270°. There were many adhesions appearing old in character which had to be freed before it was possible to untwist this loop. Even then, the colon did not seem to be entirely free but it was possible to bring the cecum into the lower right quadrant of the abdomen, and examination of the ileum at this time revealed a Meckel's diverticulum about ten inches from the ileo-cecal valve. The omentum was never visualized, if it existed. After reduction of the volvulus, the color of the involved intestine improved to such an extent that it was thought viable. The distention also decreased but later, this was found to be due to involuntary stool passed on the operating table.

A cecostomy was then performed (Stamm, but no attempt was made to remove the Meckel's diverticulum), through a right lower abdominal incision, after closing the original incision. A glass cecostomy tube was used, the wound closed about the tube and dressings applied.

The patient was in moderate shock on leaving the operating room, pulse was 148, of fair quality. Sulfadiazine was administered intravenously (sodium salt).

Course: Fever went to 105° F. during the first forty-eight hours, skin was cold and clammy. Intravenous fluids were administered freely, and continuous duodenal suction was used for five days. The cecostomy drained freely, the patient gradually improved, the temperature gradually subsided to normal, and the patient left the hospital on the 36th day, improved, having stools with enemas only, and with the cecostomy still draining. There had been intermittent spells of abdominal cramping before dismissal from the hospital, and these became gradually worse, to be followed by the loss of weight and appetite, and finally by vomiting in July, 1942 (six weeks after first operation). Fecal vomiting ensued July 8, 1942.

On July 9, 1942, he was again operated on by his family physician. This operation was reported as being long and trying, with many adhesions, the cecostomy appeared to be mechanically all right, but an obstruction was found in the upper ileum, apparently by old adhesions. These adhesions were so dense as to require resection of two inches of ileum, and side-to-side anastomosis. The postoperative condition was again very poor. For ten days he gradually improved, then after being at home for one week the wound broke down and he had fever of 101°-102°

daily, with gradual loss of weight, and foul drainage from wound, as well as fecal drainage from cecostomy.

On August 24, 1942, the patient returned to the Tulare County Hospital having moderate abdominal distention, with some tympany, but free fecal drainage from cecostomy wound. The operative wound was still draining purulent material. He was generally emaciated, and there were broncho-vesicular breath sounds at the left base posteriorly. His death from clinical pneumonia took place on August 28, 1942, just ninety days after his first admission.

Autopsy.—Performed at Tulare County Hospital, August 28, 1942. Aside from the general wasting, and the finding of a moderate degree of pneumonic process in both lungs, the most interesting information was observed in the abdominal cavity. The entire abdomen had been involved in a severe peritonitis which had caused adhesions of each loop of bowel to its neighbor, with fibrin present in all interstices. There were also several accumulations of yellow sero-purulent material both intraabdominally and in the abdominal wall itself, as well as extraperitoneally between the rectum and bladder. There was a mal-rotation of the colon, which had been partially corrected by surgery, the cecostomy being open, and no obstructive lesion appeared to remain anywhere. The mesentery of the ascending colon was fully as long as that of the transverse colon, allowing great mobility of the ascending colon. All other abdominal organs appeared normal, both externally and on cut section. The immediate cause of death was, therefore, generalized peritonitis with wound separation, and terminal pneumonia.

SUMMARY

1. The literature for the past decade on the subject of volvulus of the cecum has been reviewed in part.

2. The relationship of congenital mal-rotation, maldescent, and improper fixation of the cecum, has been discussed as an etiological factor in the occurrence of cecal volvulus.

3. A case is reported, which unfortunately terminated fatally, in spite of timely surgery.

4. The author is in complete agreement with the conclusions of Morris, and Wolfer, and others, that prompt recognition by careful history, roentgenograms made early, followed by early surgery, will give the only satisfactory results in such cases; and that cecostomy or exteriorization should be the method of choice in treating acute cases, reserving resection for patients whose general condition is very good.

303 Hyde Way.

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Oppenheim's Disease.—The describer of amyotonia congenita, Hermann Oppenheim, was also the author of important treatises on traumatic neuroses, neurology, brain tumors, myasthenic paralysis, and cerebral syphilis. He was a man of boundless energy, earnest and indomitable. By his keen interest in neurology, he not only created a successful career for himself in this field but made far-reaching advancements that left their impress upon modern neurological science.—Warner's *Calendar of Medical History.*

RUPTURE OF THE URETHRA, AND IMPASSABLE STRICTURE OF THE URETHRA*

Thomas E. Gibson, M. D.
San Francisco

THESE two separate entities are considered together because they are alike in that there is (1) dissolution of continuity of the urethra, (2) there is retention of urine, and (3) the bulbomembranous urethra is usually the site of involvement. Because of these similarities, the same general plan of treatment applies to both.

It is important at the present time that the general practitioner should have a better grasp of the fundamentals of the treatment of these conditions because of the increasing number of urethral injuries incidental to the accelerated pace of industry and the hazards of war. Unfortunately, the medical student learns little of practical value about their management in medical school, and textbook descriptions are so involved and contradictory that he is left in a state of utter bewilderment. As a matter of fact, the management of these conditions is comparatively simple provided certain principles of treatment are understood and followed.

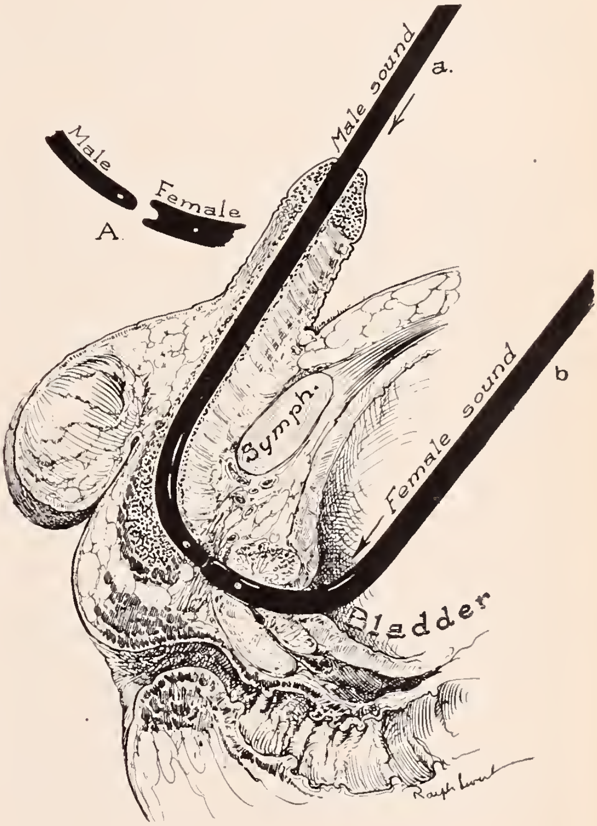

Fig. 1.—Drawing illustrating reëstablishment of continuity of urethra with Davis interlocking sound technique applicable both in rupture of the urethra and impassable stricture of the urethra. If stricture formation is so dense that sounds A and B cannot be approximated, the intervening scar tissue is excised through a small perineal incision. They are then approximated and A follows B on into the bladder. A catheter tied to A is drawn out through the urethra and left in place for permanent drainage and as a splint for healing.

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* Read before the Section on Urology, at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

RUPTURE OF THE URETHRA

Trauma to the urethra usually involves the bulbomembranous portion, sustained as a result of a blow to the perineum or falling astride some hard object, the so-called "straddle injury."

With rupture of the urethra and inability on the part of the patient to void, immediate treatment is imperative. If by gentle manipulation it is impossible to catheterize the patient, suprapubic cystotomy should be performed immediately. Cystotomy is the sheet anchor in the treatment of these cases as well as in impassable strictures. If the patient is in extremis, one should be content with cystostomy alone, and the second stage of the operation completed at a later date. Extravasation of urine and blood should of course be adequately drained by incisions of the involved areas at the first stage.

The second stage of the operation involves reëstablishment of the continuity of the urethra. The use of the Davis interlocking sounds (Fig. 1) provides the ideal solution of this problem. The female portion of the sound (b) is passed into the bladder through the cystotomy wound and guided into the prostatic urethra with the aid of the index finger until it meets the male sound (a) passed through the anterior urethra. The male sound is then passed easily on into the bladder, a catheter is tied to it and it is withdrawn, leaving the catheter in place for permanent drainage. The retention catheter is left in situ for about a week or ten days and then removed. Sounds are subsequently passed at intervals to preserve the urethral lumen and prevent stricture formation.

IMPASSABLE STRICTURE OF THE URETHRA

Strictures of the urethra are in general either (1) traumatic in origin, or (2) inflammatory. Most inflammatory strictures are of gonorrheal origin. Practically all impassable strictures, whether traumatic or inflammatory in origin, are located in the bulbomembranous urethra. Strictures of the urethra which cannot be dilated satisfactorily with sounds but which permit the passage of filiforms and followers to the bladder may be cut with the urethrotome (internal urethrotomy). Impassable strictures are best treated with the Davis interlocking sound technique exactly as described above for rupture of the urethra. In many cases, the strictured area may be so resistant that the interlocking sounds cannot be readily approximated. In that event, the following procedure is carried out: The patient is placed in lithotomy position and both the suprapubic and perineal regions are surgically prepared. The Davis interlocking sounds are approximated as nearly as possible and held in place by an assistant. The surgeon then can readily palpate the end of each sound through the perineum. The ends may be one to three centimeters apart as a result of the dense intervening urethral stricture. A small midline perineal incision is made between the ends of the sounds and the strictured area excised, thus permitting the two sounds to come together. The operation is then completed as described above for rupture of the urethra. A retention catheter is drawn in place through the urethra and permanent drainage maintained for ten days or two weeks. No sutures are necessary to approximate the severed ends of the urethral mucosa. Nature amply provides the necessary union about the catheter as a guide.

Considerable practical experience with this procedure has given convincing proof of its value as compared with the tedious and difficult perineal dissections that have hitherto been made in attempts to restore the continuity of the urethra.

CONCLUSIONS

A simple procedure applicable alike to the treatment of rupture of the urethra, and impassable stricture of the urethra, is described which practical experience has shown to be highly successful. These remarks may be interpreted as a testimonial to the Davis interlocking sounds, and rightly so, because they have brought order out of chaos and make it possible for the general practitioner as well as the specialist to manage these hitherto difficult cases with greater ease and success with a consequent reduction in morbidity and mortality rates.

450 Sutter Street.

A PSYCHIATRIST-AT-LARGE IN JAPAN*

Z. M. L.
Japan

On a recent trip to Tokyo, about a month after the occupation, I had an unusual opportunity to visit a Japanese medical school and teaching hospital. Our interpreter and guide was an excessively polite and immature looking college student named Taro. He had agreed to take us to Keio University Medical School where his cousin was in his third year. Keio University houses one of the seven large medical schools in Tokyo and is located in a section called Yotsuya, about five miles from the center of the city in a semi-residential district.

As we entered the grounds we noticed that many of the buildings had been damaged or destroyed. We were later informed that a third of their buildings, including the section for first class patients had been burned to the ground. Another third was seriously damaged and the remaining third was untouched. We were ushered into the library building, a memorial to one of their distinguished alumni, and introduced to Dr. S. Uiematsu, Professor of Neurology and Psychiatry and a graduate of Harvard University Medical School, class of 1922. It was shortly after twelve noon and the faculty was just finishing lunch in a large conference room, richly paneled in dark wood. Professor Uiematsu introduced us to the rest of the faculty and apologized for the absence of the dean who was out of the city. He showed us to chairs in an adjoining reception room and invited us to have luncheon. Being aware of the serious food shortage in Japan we declined his hospitable gesture, but he called for a pot of Japanese tea in which we all joined. In turn we offered him some American cigarettes which he smoked with obvious relish.

The professor was a small, serious man of about 50 years, with a tiny moustache and greying hair. He wore the conventional thick glasses and was dressed in a conservative tweed of American cut. His English was a bit slow and soft spoken, but his choice of words was exact. He spoke of his psychiatric training under the late Dr. Macfie Campbell with more than a trace of nostalgia. He looked rather subdued and sad as if to imply that the happenings of the last ten years were not of his choosing. He was very dignified, attentive, and polite to us as visitors, but there was none of the fawning and obsequious behavior which appears to be so prevalent among the conquered Nazis. We talked as colleagues and he answered all questions willingly and apparently without reserve.

We spoke first of psychiatry. He told us that the Japanese psychiatrists had anticipated a large number of psychiatric casualties following the B-29 bombing raids. They received only one-half the estimated number among the civilian population. (This is strikingly similar to the British experience as reported by Col. Gillespie.) There has been no relative increase in the incidence of psychoses in either the civilian population or in the Armed Forces. This, too, appears to be a universal experience. When I inquired about the incidence of psychoneuroses in the Armed Forces he smiled wryly and stated that, of course, they occur, but are not called by that name for reasons of military expediency. He felt that there was perhaps a slight increase in the incidence of general paresis during the war but practically no other changes in the incidence of psychiatric illnesses.

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* The letter that follows was received by CALIFORNIA AND WESTERN MEDICINE from a friend in the U. S. Navy. Its interesting observations explain its appearance in this department.—Ed.

The Japanese have been familiar with all the recent forms of shock therapy and are still using insulin in schizophrenia, particularly in the catatonic form. When I asked if he followed the Sakel technique he seemed to be unfamiliar with the name and did not know that Sakel had introduced insulin shock therapy over ten years ago. This was explained by the fact that all the recent European medical literature available in Japan was of Nazi origin. Since Sakel was a Viennese Jew, his name had apparently been carefully deleted from all the literature on insulin therapy. Prof. Uiematsu mentioned that the Japanese had been using an insulin derived from fish pancreas which was found to be very effective in producing hypoglycemia. This is not too surprising when it is remembered that Japan is not a meat-eating country but depends chiefly on fish for its animal protein.

Metrazol (or Cardiazol, as it is known in Japan) was used in 1938 and 1939, but for the last five years electroshock therapy has been employed. It is still being used with considerable success in the treatment of the depressions. On inquiring further, I learned that all treatments are given in hospitals; none is given in homes or out-patient clinics. Curare has not been used to cushion the shock of the convulsion and, in fact, he was ignorant of its use in this regard.

Prefrontal lobotomy has been performed on a large series of cases by Dr. Nakada of Niigata University Medical School. Many of the patients were, surprisingly enough, manic-depressives in the manic phase. His results were apparently encouraging enough for him to continue with the operation. He uses the lateral approach with a simplified leucotome, similar to that used by Freeman and Watts.

Psychoanalysis has apparently had very little following in Japan. Prof. Uiematsu could think of only one psychiatrist practicing analysis. This psychiatrist had also studied in the United States with Dr. Adolph Meyer shortly after World War I, and is still practicing in Tokyo.

I asked Prof. Uiematsu about his experience with sodium amytal or pentothal narcotherapy. Not only had he never used it, but he was quite unaware of its value in military and civilian psychiatry. He exhibited great interest in the subject and I referred him to a few of the leading articles in some of the American journals to which he might soon have access and he was very grateful.

We also questioned the professor on more general medical topics. He said that malnutrition was Japan's pressing problem. Despite this, there were very few cases of beriberi and practically no cases of deficiency polyneuritis. This is eloquent testimony to the efficacy of the governmental edicts insisting on the use of unpolished rice in the diet. Tuberculosis is definitely on the increase and postoperative wound infections are numerous because of the decreased resistance of the patient and the breakdown in aseptic techniques in the under-staffed and bomb-shattered hospitals.

Prof. Uiematsu next showed us through the Keio University Hospital which is the teaching hospital in direct connection with the medical school. They used to take in three classes of patients but now have facilities for only the lower two classes since the building that housed the first class patients was destroyed. The 3rd class patients pay 4 yen (about 60c) per day and the 2nd class patients pay 8 to 10 yen. Despite a large number of white gowned orderlies and nurses, the floors and walls of the 3rd class section were filthy and the ward smelled badly. Some one had started to burn some fragrant charcoal in a porcelain urn but this did not help matters appreciably. Each bed was separated from its neighbor by dirty white sheets which were kept draped about the bed all day, giving each patient a certain amount of privacy. The relatives of the patients who were present in large numbers were either hovering anxiously about the patient, or running up and down the narrow corridors on various errands adding immeasurably to the confusion. The beds were of the standard hospital type, but in each cubicle the patient usually had some prized household *objet d'art* —a doll, a figurine, or some treasured possession—on a prominent place near him.

In the large tiled bathroom and toilet (only one on each floor for both sexes) we found a Japanese woman busily engaged in building a twig fire on the floor to warm some home-made food she had brought for one of her relatives. This practice is no longer uncommon and, in fact, is encouraged by the hospital since it is almost impossible for the institution to scrape together enough food to feed its patients adequately. The washroom was large and well designed, but was suffering from neglect. The toilets or "benjos" were of the characteristic Japanese variety, built almost flush with the floor and shaped like a miniature porcelain gondola with a splash-proof prow. In Japan one must be able to squat with agility and accuracy.

We were taken next to the psychiatric wing for 2nd class patients, the only facilities remaining. There was room for about twenty patients but only ten rooms were occupied. These were quite elegant in comparison with the accommodations for the 3rd class patients. Each patient had a large private room which appeared to be decorated and arranged according to the individual taste of the occupant or one of his relatives. A large section of the room was raised about 8 inches to make a platform which was covered with finely woven straw matting. Part of this raised platform was used as a bed by the patient, who lay covered with beautiful thick comforters in richly colored silks. Some of the patients had their own furniture moved in to make things more "homey." A distinguished and elaborately robed man of 50 years sat cross-legged on the floor in front of an ornate kakemono scroll; a case of pre-senile psychosis. A lady in a room across the hall lay in bed completely mute, her unseeing eyes fixed in the typical expression of catatonia. A third patient in his 50's was being treated for general paresis by typhoid injections. Therapeutic malaria is usually employed, but in this case Prof. Uiematsu felt that the patient was too old and feeble to withstand such rigorous treatment.

We made a brief tour of the remaining parts of the hospital. The laboratory was a large but poorly kept room full of dirty glassware and antiquated apparatus. In one corner were several bottles of mold-covered urine which had apparently been standing for days. Everything looked run down, dirty and neglected. The pharmacy contained a few glass jars of old drugs and herbs. Even these were meagre in quantity and the doctor complained bitterly that it was almost impossible to get essential drugs and medications. I commented that the caves honeycombing the hills near the Japanese Naval Hospital at Yokosuka were crammed to the top with fine instruments and drugs, mostly of German manufacture. He smiled sadly and said, "Ah yes, for the military there was never any shortage." The large operating room contained two tables of fairly modern design, but the wall plaster was badly cracked and huge flakes of old paint threatened to fall from the ceiling. The x-ray equipment was all antiquated and it was impossible to get replacements for worn parts.

As we walked down the stairs, we noticed that all the metal treads had been removed from the edges of the terrazzo steps. When I inquired about the reason for this, the professor smiled and said quite slowly, "They went into our last big scrap drive—over a year ago!"

Japan, December 3, 1945.

CLINICAL NOTES AND CASE REPORTS

FOOT STRAIN: A VALUABLE SIGN

Lewis Cozen, M. D.
Los Angeles

THE following is a simple test for the diagnosis of foot strain. Although the sign is well known among orthopedists, other practitioners are generally not familiar with it. Tenderness is felt over the center of the medial border of the longitudinal arch. If pain is present on moderate pressure here a diagnosis of foot strain can usually be made.

It may seem presumptuous to mention so simple a test. The clinical value of the sign has nevertheless not been sufficiently emphasized. The diagnosis of foot strain is often difficult to make. Indeed it is frequently made by exclusion. The examiner eliminates the possibility of peripheral vascular disease, of inflammatory disease and of trauma, and thus static strain is left as the cause of the patient's painful feet. It is evident that if a positive sign for the diagnosis of foot strain could be made rather than a diagnosis by exclusion we would have a more conclusive diagnosis. The presence of valgus deformity of the foot is itself insufficient evidence for a diagnosis of foot strain. Anyone who has examined many human feet has noted many flat feet that caused no symptoms. Therefore, a patient may have flat feet, yet the pain in his feet is not necessarily a result of the deformity. Furthermore, he may have pain in his legs or pain in his back without any pain directly in his foot, and yet all his symptoms may be caused by foot strain. What is the cause of this tenderness in the center of the inner border of the foot? In this area the tendons of insertion of both the Tibialis Anticus and of Tibialis Posticus are very superficial. On dissection of the insertions of these two tendons one will find the tendoosseous junction surrounded by thin connective tissue having the appearance of a bursa. This filmy connective tissue is both superficial to and deep to the tendinous insertion, and it is probable that this tissue undergoes slight non-specific inflammatory changes. Why should there be irritation at the insertion of these two tendons, the Tibialis Anticus and Tibialis Posticus? Because the entire weight of the body with each step stretches the tendinous insertion. Because the tendons can be easily pressed and irritated between the tarsus and the shoe. (Illustrations of cross sections of the tarsus, appearing in volumes on anatomy, show the superficial position of the tendons of the tibialis anterioris and posterioris.)

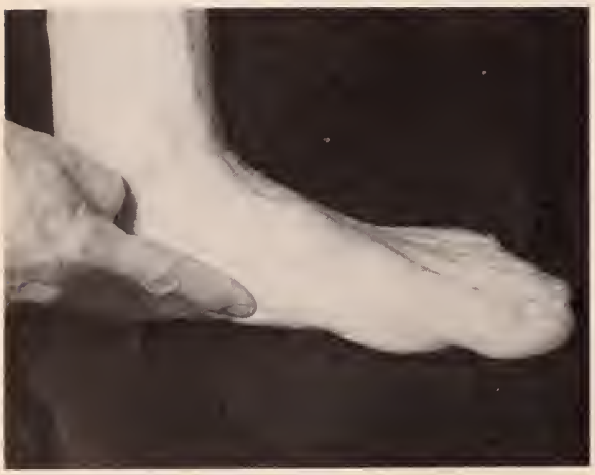

Fig. 1.—Palpation for tenderness to determine presence of strain.

The feet of twenty individuals were used as controls. These twenty adults had no complaints referable to their extremities or to their back. In none of these twenty people was any tenderness present on pressure over the medial border of the foot.

SUMMARY

A simple test for foot strain is emphasized. It consists of point tenderness over the center of the inner border of the tarsal area.

2007 Wilshire Boulevard.

OBSCURE LYMPHOSARCOMA

Howard A. Ball, M. D.
San Diego

THIS case is reported not only because it seems to offer a fair opportunity to correlate changes in the differential blood count with the x-ray therapy administered but also to raise a question concerning therapeutic procedure under similar circumstances.

REPORT OF CASE

A white female of 53 years, presented herself with multiple nodular swellings in the neck, axillae and groins and a complaint of generalized abdominal pain and swelling which followed a fall on the abdomen two months previously. She had lost 20 pounds during this two months. She was found to have a left post-pharyngeal swelling, generalized discrete lymphadenopathy and a palpable tender spleen. The lymph nodes were only moderately enlarged. The initial blood count showed 10,150 WBC with 64 per cent lymphocytes, equivalent to about 6,500 lymphocytes per cu. mm. Normally with a 10,000 cell count and a maximum of 35 per cent lymphocytes we would see that 3,500 would be about the high level of normal. Thus her circulating lymphocytes were not quite double the figure but no immature forms were recognized.

An inguinal node was removed for study and findings reported "compatible with leukemic lymphadenosis but they do not warrant a diagnosis of lymphosarcoma."

X-ray therapy was given on the basis of the tissue diagnosis, treating the spleen, both sides of the neck, both axillae and both groins in a system of rotation. Five days after 100 r over the spleen the circulating lymphocytes had dropped from 6,500 to 1,600 per cu. mm.—a rather dramatic change. Four days later, however, this low figure had more than doubled to 3,535 per cu. mm., but at no time subsequently did it ever significantly exceed this figure.

During the first four months a total of 1,500 r were given, 300 r of this over the spleen. At four and one-half months a sudden reversal in the differential count occurred. Nine counts during the initial period had shown an average of 60 per cent of the circulating white blood cells to be lymphocytes. Fourteen counts during the next year and one-half showed an average of only 33 per cent. At one time a year after treatment was instituted the treated glands had disappeared and the intern who saw the patient in good condition in the clinic recorded that "with this blood count I am skeptical patient ever had leukemia."

During the next four months the patient had some discomfort over the left side and groin and tenderness over the coccyx, and was not seen again for nearly a year when she entered the hospital with bleeding from the nose, anorexia, weakness, loss of weight and migrating skeletal pains. The spleen and a few small inguinal nodes were palpable and the white count showed a total of only 2,000 cells per cu. mm., 68 per cent of which were lymphocytes. Death occurred three weeks later.

The autopsy showed scattered foci of neoplasm along the spine and ribs, about the celiac axis and in the hilus of the spleen and along the abdominal aorta. The spleen and liver were moderately enlarged and the kidney parenchyma adjacent to the pelves was infiltrated with tumor. Both the sternal and femoral bone marrow were almost white from neoplastic involvement.

Final diagnosis: lymphosarcoma.

COMMENT

It may be observed that those areas of most extensive involvement at autopsy are almost without exception those areas not subjected to radiation previously. The spleen is the only exception, and this area was not treated on the presumption of neoplasm. We are faced, then with the question of whether in a case of systemic lymphadenopathy that responds well to external radiation we should not also include treatment to the visceral gland-bearing areas lying chiefly along the midline of the thorax and abdomen, even in the absence of symptoms referable to them. I am inclined to believe that we should.

233 A. Street.

VINCENT'S ANGINA—SOME DIAGNOSTIC PITFALLS*

CAPTAIN NICHOLAS P. POPOV
MEDICAL CORPS, ARMY OF THE UNITED STATES
San Francisco

THE usual symptoms of Vincent's angina of the tonsils are acute or subacute tonsillitis. Temperature ranges from normal to 103° F. Patient complains of headaches, chilly sensations, generalized malaise, sore mouth and gums and pain in swallowing. Some patients have no constitutional disturbances and the condition is recognized only on objective examination. Other patients may exhibit most violent symptoms, submaxillary and cervical gland enlargements, tenderness and severe pain on talking or swallowing. All have fetid breath. The ulcer may be single or multiple, commonly involving one tonsil, most frequently at its upper part. At other times both tonsils are involved or the ulcers may spread to the soft palpate, pharynx and the gums. As a rule, the ulcers are grayish-white, surrounded by a red, inflamed areola and bleed easily after palpation or removal of the membrane. A debilitated state of health, decayed teeth, oral uncleanliness and inflamed gums, favor the development of the disease.

The clinical diagnosis is confirmed by microscopic examination of a fresh smear taken directly from the ulcer, or a section of the pseudomembrane, and discovery of the fusiform bacillus and spirillum which are the typical Vincent's angina bacteria.

The disease is acute, subacute or chronic and is subject to recurrence.

AUTHOR'S SERIES

During the period of a year, 164 patients were admitted 176 times to the Station Hospital, DAAB, DeRidder, Louisiana, with diseases of the tonsils. Some of the patients came in with chief complaints other than referable to the tonsils.

Disease	*No. of Patients*	*No. of Admissions*
Vincent's angina, tonsillar	17	18
Tonsillitis, hypertrophic, acute	26	30
Tonsillitis, hypertrophic, chronic	78	79
Tonsillitis, follicular, acute	36	41
Tonsillitis, follicular, chronic	7	8
Total	164	176

Some 10.5 per cent of all admissions for disease of the tonsils were tonsillar Vincent's angina; 4.2 per cent of all tonsillectomies, or 4 out of 98 operations, were performed as a result of tonsillar Vincent's angina.

Vincent's angina is frequently confused with follicular (Lacunar) tonsillitis, diphtheria, syphilis and acute leukemia. Each case of disease of the tonsils that was admitted in which Vincent's angina, tonsillar, was suspected, received a Kahn test to rule out syphilis, and a smear to confirm clinical diagnosis of Vincent's angina, and to positively rule out follicular tonsillitis and diphtheria. Acute leukemia was excluded by a complete blood count.

One case of infectious mononucleosis had acute follicular tonsillitis that clinically had a characteristic appearance of Vincent's angina. A smear was taken three times, but each time was unsatisfactory for microscopic examination.

Another case of Vincent's angina of the tonsils had extensive ulcerative lesions on the mucous membranes of the mouth.

Three cases were complicated by stomatitis, ulcerative, due to Vincent's organisms.

One case of acute hypertrophic tonsillitis and three cases of acute follicular tonsillitis were complicated by peritonsillar abscess.

Most of the patients were treated by their squadron surgeons first, and if they failed to improve, were sent into the Nose and Throat Clinic where they were hospitalized.

The diagnosis of acute and chronic hypertrophic tonsillitis and of chronic follicular tonsillitis constituted no diagnostic problem, but most of the Vincent's angina cases were diagnosed by squadron surgeons as acute follicular tonsillitis. Some patients were treated in their organizations as long as 10 days for acute follicular tonsillitis until they were referred to the Ear, Nose and Throat Clinic and diagnosed as Vincent's angina of the tonsils.

Of the acute suppurative tonsils, there were 41 admissions with acute follicular tonsillitis and 18 with Vincent's angina of the tonsils. From that study of acute tonsils with suppuration, 30.5 per cent were Vincent's angina.

COMMENT

Of all the admissions for diseases of the tonsils, 10.5 per cent were diagnosed as tonsillar Vincent's angina, and 30.5 per cent of all acute suppurative diseases of the tonsils were similarly diagnosed.

Because of the high incidence of Vincent's angina of the tonsils and its easy transmission from one person to another by dishes, towels, kissing, etc., it is urged that all cases suggestive of Vincent's angina be more closely inspected by means of a smear for more accurate diagnosis.

With greater alertness on the part of every physician for possible Vincent's angina, the incidence of this disease could be reduced both in armed forces and among civilian population, saving thousands of people from temporary disability.

AAF Regional Hospital, Drew Field, Tampa, Fla.

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* This article has been released for publication by the Review Branch, War Department Bureau of Public Relations. The opinions and views set forth in this article are those of the writer and are not to be considered as reflecting the policies of the War Department, or the military service at large.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

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SAM J. McCLENDON, M.D. .... President-Elect
E. VINCENT ASKEY, M.D. .... Speaker
LEWIS A. ALESEN, M.D. .... Vice-Speaker
PHILIP K. GILMAN, M.D. .... Council Chairman
JOHN W. CLINE, M.D. . . Chairman. Executive Committee
GEORGE H. KRESS, M.D. . Secretary-Treasurer and Editor
JOHN HUNTON .... Executive Secretary

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COMMITTEE ON SCIENTIFIC WORK

75TH ANNUAL SESSION

California Medical Association

AT LOS ANGELES

Tuesday, May 7 - Friday, May 10, 1946

Make note of these dates on your Calendar.

The official headquarters of the next annual session of the California Medical Association to be held at Los Angeles, Tuesday, May 7 through Friday noon, May 10, 1946, will be the *Hotel Biltmore,* 515 South Olive Street (Olive, between Fifth and Sixth Streets), Los Angeles. Because of postwar conditions and prospective attendance, the facilities of other hotels must also be used.

All requests for reservations must be sent to the hotels direct. In writing, it is well to state the number in the party, date of arrival, date of departure, nature of accommodations desired (single room, double room, double bed, twin beds, bath).

LOS ANGELES HOTELS: WITH TELEPHONE NUMBERS

A list of some hotels in Los Angeles within easy distance of the Hotel Biltmore follows:

Hotels	*Telephones*
Alexandria Hotel, 210 W. Fifth St.	(MAdison 2741)
Ambassador Hotel, 3400 Wilshire Blvd.	(DRexel 7011)
BILTMORE HOTEL, 515 S. Olive	(MIchigan 1011)
Carlton Hotel, 519 S. Figueroa St.	(MIchigan 6571)
Chapman Park Hotel, 516 S. Alexandria Ave.	(FItzroy 1181)
Clark Hotel, 426 S. Hill St.	(MIchigan 4121)
Gates Hotel, 831 W. Sixth St.	(TRinity 3931)
Hayward Hotel, 206 W. Sixth St.	(MIchigan 5151)
Mayfair Hotel, 1256 W. Seventh St.	(FItzroy 4161)
Mayflower Hotel, 535 S. Grand Ave.	(MIchigan 1331)
San Carlos Hotel, 507 W. Fifth St.	(MUtual 2291)
Savoy Hotel, 601 W. Sixth St.	(MAdison 1411)
Stillwell Hotel, 838 S. Grand Ave.	(TRinity 1151)
Town House, 639 S. Commonwealth Ave.	(EXposition 1234)
William Penn Hotel, 2208 W. Eighth St.	(EXposition 3181)

A.M.A. Session

American Medical Association will hold its annual session this year in San Francisco. Dates: Monday, July 1 - Friday, July 5, 1946.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (55)

Alameda County (3)

Larsen, Loren J., *San Francisco*
Neustadter, Rudolph, *Oakland*
Peters, Harry E., Jr., *Oakland*

Los Angeles County (42)

Adler, Denis C., *Los Angeles*
Afflerbaugh, Jack Kenneth, *Pomona*
Alexander, Harold B., *Los Angeles*
Asher, Leonard M., *Beverly Hills*
Ashley, Mina Marie, *Huntington Park*
Bachman, George Willaim, Jr., *Van Nuys*
Blacker, Morris R., *Los Angeles*
Brodkin, Myer F., *Pacific Palisades*
Byram, Roy Mack, *Long Beach*
Conner, Lyman H., *Burbank*
Christman, Robert H., *Whittier*
Diskin, Herman E., *Los Angeles*
Dockham, Charles William, *Los Angeles*
Eastman, Verne E., *Long Beach*
Exelby, Paul A., *Whittier*
Fishman, Harold C., *Los Angeles*
Forde, Wells E. A., *Los Angeles*
Getz, Horace R., *Pasadena*
Gilbert, Wallace G., *Downey*
Goggin, Chester W., *Los Angeles*
Guth, Harvey K., *Los Angeles*
Heaney, N. Sproat, *Tarzana*
Horowitz, William, *Beverly Hills*
Kaplan, Louis Harvey, *Los Angeles*
Kildebeck, Jerry C., *Huntington Park*
Knox, Lawrence M., *Pacific Palisades*
Leff, Meyer Isaac, *Santa Monica*
Lerner, Milton, *San Fernando*
Mayer, J. DeCosta, *Los Angeles*
Parker, Donald DeWitt, *Pasadena*
Paxman, Curtis R., *Norwalk*
Popovich, Stephen J., *Los Angeles*
Richards, Paul S., *Pasadena*
Rossen, Allan Morris, *Los Angeles*
Spritzler, Ramon J., *Los Angeles*
Vixie, Loren O., *Los Angeles*
Walt, Richard W., *Los Angeles*
Watkins, Albe M., *Montrose*
Weir, John J., *Glendale*
Winer, Louis Harry, *Beverly Hills*
Winsor, Travie, *Los Angeles*
Wyatt, Bernard L., *Los Angeles*

Orange County (1)

Unger, John B., *Santa Ana*

Placer-Nevada-Sierra County (1)

Smith, Judith D., *Colfax*

San Francisco County (8)

Broderick, Thomas A., *San Francisco*
Conlan, Francis J., *San Francisco*
Dennis, Robert Lee, *Philadelphia, Pennsylvania*
Diamond, Bernard Lee, *San Francisco*
Eaker, Alan B., *San Francisco*
Galgiani, John V., *San Francisco*
Hawkins, George William, *San Francisco*
Rittenberg, Beatrice M., *San Francisco*

Transfers (9)

Blount, Lester L., from *Monterey County* to *Orange County*
Farber, Jason E., from *San Francisco County* to *Alameda County*
Silverglade, Alexander, from *Alameda County* to *Los Angeles County*
Sinay, Henry R., from *Fresno County* to *Los Angeles County*
Smith, R. Esmond, from *San Bernardino County* to *Los Angeles County*
Tirico, Joseph G., from *Santa Barbara County* to *Orange County*
Wheeler, Dorothy F., from *San Francisco County* to *Butte-Glenn County*
Woro, Benjamin, from *Merced County* to *Contra Costa County*
Yahn, III, George W., from *Fresno County* to *Ventura County*

Resignations (1)

Schussler, Herman, Jr., *San Francisco County*

In Memoriam

Blood, John Nelson. Died at San Mateo, December 26, 1945, age 57. Graduate of the College of Physicians and Surgeons of San Francisco, 1914. Licensed in California in 1915. Doctor Blood was a member of the San Mateo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Brazda, Ctimir Silas. Died at Los Angeles, December 8, 1945, age 46. Graduate of the University of Illinois College of Medicine, Chicago, 1942. Licensed in California in 1943. Doctor Brazda was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Bullock, Annie Sophia. Died at Alhambra, December 7, 1945, age 72. Graduate of the Woman's Medical College of Pennsylvania, Philadelphia, 1912. Licensed in California in 1913. Doctor Bullock was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Clark, James Harvey. Died at Linz, Austria, December 11, 1945, age 48. Graduate of Johns Hopkins University School of Medicine, Baltimore, Maryland, 1936. Licensed in California in 1939. Doctor Clark was a member of the Monterey County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Evans, Newton Gurdon. Died at Los Angeles, December 19, 1945, age 71. Graduate of Cornell University Medical College, New York, 1900. Licensed in California in 1915. Doctor Evans was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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† For roster of officers of component county medical societies, see page 4 in front advertising section.

Franklin, Walter Scott. Died at Santa Barbara, January 2, 1946, age 67. Graduate of the Cooper Medical College, San Francisco, 1898. Licensed in California in 1898. Doctor Franklin was a member of the Santa Barbara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Green, Carl Victor, Jr. Died at Inglewood, December 18, 1945, age 45. Graduate of the University of Southern California School of Medicine, Los Angeles, 1933. Licensed in California in 1933. Doctor Green was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Jackson, Josephine Agnes. Died at Palo Alto, December 31, 1945, age 80. Graduate of Northwestern University Woman's Medical School, Chicago, 1896. Licensed in California in 1905. Doctor Jackson was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARY

Newton Gurdon Evans
1874—1945

Newton Gurdon Evans was born in Hamilton, Missouri, June 1, 1874. He received his medical degree from Cornell University Medical School in New York in 1900. Early in his medical career he began work in the field of pathology, and after having taught this subject for a short period of time at the old American Medical Missionary College in Battle Creek, Michigan, he moved to Tennessee in 1908, where he taught pathology at the University of Tennessee School of Medicine until 1911.

Dr. Evans accepted an invitation to join the College of Medical Evangelists, in which school he became president and professor of pathology in 1914. He remained professor and head of the department of pathology until the time of his death. When Dr. Percy Magan was made president of the school in 1927, Dr. Evans became dean, in which capacity he served until 1931. He was pathologist and director of the laboratory at the Los Angeles County Hospital between 1931 and the time of his retirement on June 30, 1944. At that time he again became dean of the College of Medical Evangelists, in which capacity he served for one year, but on account of failing health was forced to relinquish these responsibilities.

As a teacher of medical students Dr. Evans was outstanding. As a scientist he made many contributions to medicine, and among those who knew him best he was always respected for his complete honesty and his sturdy integrity.

He was a bibliophile of no mean ability, and his continued interest in many libraries caused him to be appointed as one of the counselors for the Surgeon General's Library.

He was a Fellow of the American Medical Association and of the American College of Physicians. He was a member of the American Society of Clinical Pathologists, the Los Angeles Academy of Medicine, the Los Angeles Pathological Society, the Los Angeles Cancer Society, the American Association of Pathologists and Bacteriologists, as well as having membership in the Los Angeles County Medical Association and in the California State Medical Association.

He died in Los Angeles on December 19, 1945, from carcinoma. He is survived by a son, Dr. William D. Evans, who is an instructor in internal medicine in the College of Medical Evangelists, and by a daughter, Mrs. Howard A. Ball, of San Diego, California.

COMMITTEE ON HISTORY

Los Angeles County Medical Association Celebrates Its 75th Anniversary in a Diamond Jubilee Banquet

The Bulletin of the Los Angeles County Medical Association of January 17, 1946, contained the following full page announcement:

Diamond Jubilee Banquet—Jan. 31

MAKE YOUR RESERVATIONS NOW!

On Thursday evening, January 31, 1871, the Los Angeles County Medical Association was organized.

On Thursday evening, January 31, 1946, the Los Angeles County Medical Association will observe its seventy-fifth anniversary at a Diamond Jubilee Banquet at the Biltmore Bowl.

A most interesting and entertaining program has been arranged—largely historical in character to bring together many members who remember well the happenings of years ago.

This will be followed by the complete Bowl program of excellent entertainment, and dancing.

If you have not made your reservations, make them now.

The price is $6.00 per plate. No extra charge for entertainment.

Dinner at 7 o'clock, sharp.

* * *

The Los Angeles County Medical Association invited the officers and council of the California Medical Association to be guests on this occasion. C.M.A. Council will hold a meeting on next day, February 1. Concerning the banquet, more in a later issue of CALIFORNIA AND WESTERN MEDICINE.

* * *

From the January 17 issue of *The Bulletin,* also the following historical comment by its editor, Secretary E. T. Remmen:

IN RETROSPECT

As the Los Angeles County Medical Association completes its first 75 years of existence, a backward glance at a few of its accomplishments may be of interest.

The society had scarcely been named in 1871 when it undertook the literally Herculean chore of cleaning up the pueblo of Los Angeles. Cholera, typhoid, smallpox and various "malarious" diseases were rampant, nourished by fly-infested piles of refuse and garbage left to rot or be eaten by passing animals. Dead dogs and cats lay in the streets until the stench forced their removal. A cemetery on the hill just north of the little city sent the run-off from unembalmed bodies into wells which furnished drinking water. Sewage, discharged into open ditches or zanjas, was used to irrigate and fertilize vegetable gardens between Los Angeles and the sea. Yellow fever and bubonic plague were constant threats. The citizenry, moreover, had scant knowledge of sanitation and saw no reason to adopt expensive and, as they saw it, wasteful methods of sewage disposal.

Seven physicians, members of the new society, by a forceful program of education and persuasion brought about a change. As the group slowly grew, others added their voices and Los Angeles became a clean and wholesome city. Sewage was piped to the ocean, garbage heaps eliminated, and the cemetery moved. Our sewage disposal still leaves much to be desired, but public opinion, informed and enlightened by the medical profession, no longer tolerates filth. No public official could now remain long in office if he allowed motives of profit to outweigh those of public safety and sanitation. Vaccination against smallpox, for which our early members fought, is now an accepted procedure, opposed only by occasional crackpots.

The health departments of the city and county were founded and continued at the insistent demand of the Association. Without its coöperation and support, they would quickly have succumbed to the forces of ignorance and commercialism. Some of our most outstanding members have served as health officers, either part or full time. Their accomplishments have been notable, but not gained without struggle. Cleaning up the milk and meat supply, the inspection of restaurants and food handlers, proper garbage and sewage disposal, sanitary plumbing and numerous other advances have all cost someone money and have all been bitterly opposed. The Association, through the years, has invariably supported our health officers in matters which properly come within their purview, but has quickly and effectively curbed their occasional attempts to engage in the treatment of other than communicable disease. Our Medical Milk Commission has established a standard for certified milk which is the envy of most cities.

The county hospital, now an admirable institution, was not always so. As recently as 1911, our Association recommended to the Board of Supervisors that tuberculosis wards be screened, that manure piles be abolished, and internes provided with medical journals and books. Our society has steadily, quietly and consistently brought about improvements in all our public charitable institutions by presenting facts and logical arguments to public officials, or if that failed, to the public. By contrast, the periodic "exposes" of hysterical and unscrupulous newspapers have merely undermined public confidence in these institutions which are truly the refuge of the poor in their hour of need.

Among the early accomplishments of our Association was the establishment by its members of the College of Medicine of the University of Southern California. This took place in 1885. The prime mover was Dr. Joseph Pomeroy Widney, one of the Asosciation's founders and the first Dean of the college. This school, although small and with limited funds, from the first had entrance and graduation requirements second to none in the United States. Almost every member of the Association at that time had a part in the work of teaching. Much of the clinical instruction, then as now, was given at the County Hospital and served to bring its standards abreast of the times. Apart from the fact that it trained many young men and women who became eminent physicians, the college played an invaluable rôle in carrying the gospel of modern medical science to the public. In recent years the same institution, reorganized, has continued its excellent work, in which it has been joined by the College of Medical Evangelists.

To recount something of the Association's attainments, its development of scientific sections, the growth of its library, the building of a permanent home, its assistance to hospitals and clinics desiring to establish high standards, its battles in behalf of sound medical legislation and a hundred other activities, has been the aim of the writer and his associates in preparing the brief history of the Los Angeles County Medical Association which will soon be in the hands of members and *Bulletin* subscribers. Space limitations have prevented the inclusion of much material, biographical and scientific, which would have added to the value of the volume. If the work stimulates greater interest in the Association, it will be well worthwhile. Possibly another history, written from the biographical viewpoint, may some day be prepraed.

Much remains for the future. Great discoveries have been made; greater ones are to come. Chemotherapy is only beginning. Public understanding of the possibilities of medical science is limited and confused. Only through education of the people can quackery and charlatanism be eliminated. Medical organizations must continue to resist the schemes of politicians and misguided reformers to submerge medicine in a vast bureaucracy. Attempts to distribute the cost of serious illness through voluntary insurance are proceeding apace and should render compulsory health insurance superfluous.

A glorious future beckons to Medicine. Let us make our Association's part in that future one of which its noble founders would be proud.—E.T.R.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

Proposed Change in the Constitution of the Woman's Auxiliary to the California Medical Association

(Approved by C.M.A. Council on January 9, 1946.)

Article 5—Board of Directors:

Insert Section 6:

(a) In the event death, resignation or other reason causes the office of the President to become vacated; the President-Elect, in conjunction with the duties of that office, shall immediately become President for the unexpired term as well as the succeeding year to which she has been elected.

(b) In the event death, resignation or other reason causes the office of the President-Elect to become vacated; the nominating committee shall within six weeks, nominate and present to the Board of Directors, a candidate for that office at the next meeting of the Board of Directors, this to be placed on the agenda of that meeting. Further nominations may be made from the floor. When necessary, election may be held by mail vote.

(c) In the event the office of President-Elect becomes vacated within six weeks of the annual meeting, the nominating committee shall nominate and present for election a candidate for that office to the House of Delegates. Further nominations may be made from the floor.

(d) In the event the office of First Vice-President, Second Vice-President, Recording Secretary or Treasurer becomes vacated, the Board of Directors shall elect some active member of the Auxiliary to serve the unexpired term of said office.

(e) Vacancies occurring among the offices of Councilor-at-Large, District Councilors and committee chairmen shall be filled by appointment of the President, subject to the approval of the Board of Directors.

(f) To be eligible for election, succession or appointment as President or President-Elect, a member must have served as an officer or as a chairman of a standing committee for at least one year.

Article IX, Section 1:

At present reads:

A Nominating Committee shall be elected each year in advance and shall consist of five members. Two of these members shall be elected by the Board of Directors at the Fall Board meeting and three, to be members-at-large, shall be elected by the House of Delegates. The Chairman shall be designated by the Board of Directors.

For sake of clearness, *shall read:*

A Nominating Committee shall be elected each year in advance and shall consist of five members. Three of these shall be members-at-large elected by the House of Delegates at the annual meeting, and two will be elected by the Board of Directors at the Fall Board meeting. The chairman shall be designated by the Board of Directors.

Article XI—Meetings, Section 6:

At present reads:

The fiscal year shall correspond with the fiscal year of the Woman's Auxiliary to the American Medical Association, to wit, April 1 to March 31.

Because of the date of the annual meeting in California, *shall read:*

The fiscal year shall be from June 1st to May 31st.

Article XII, Section 2:

Now reads:

The annual assessment of dues shall be payable on or before January 1 of the year for which they are levied, and shall be delinquent after March 15 of that year.

Shall read (because of changes in the National Constitution):

The annual assessment of dues shall be payable on or before January 1 of the year for which they are levied, and shall be delinquent after February 15 of that year.

Article XII, Section 3:

Now reads:

On or after March 20 of each year, the State Treasurer shall forward the State per capita assessment as fixed by the National Auxiliary, to the National Treasurer.

Shall read (because of changes in the National Constitution):

On or before March 15 of each year, the State Treasurer shall forward the State per capita assessment as fixed by the National Auxiliary, to the National Treasurer.

Article XV—Amendments:

Now reads:

The Constitution may be amended at any regular annual meeting of this Auxiliary by a two-thirds vote of the members of the House of Delegates present and voting, PROVIDED, a copy of the proposed amendments shall have been mailed to each member of the Board of Directors and to the Secretary of each County Auxiliary at least sixty (60) days prior to the date of said meeting; and PROVIDED FURTHER, that said amendments shall have been published at least once in "California and Western Medicine" at least three months prior to the adoption thereof; and PROVIDED FINALLY, that such amendments shall, prior to the adoption thereof, have been approved by the Council of the California Medical Association evidenced by resolution thereof.

Shall read (because the Auxiliary no longer has space in "California and Western Medicine"):

The Constitution may be amended at any regular annual meeting of this Auxiliary by a two-thirds vote of the members of the House of Delegates present and voting; PROVIDED, a copy of the proposed amendments shall have been mailed to each member of the Board of Directors and to the Secretary of each County Auxiliary at least sixty (60) days prior to the date of said meeting, and PROVIDED FURTHER, that said amendments shall have been published at least once in either "California and Western Medicine" or the "State Courier" or both, at least three months prior to the adoption thereof; and PROVIDED FINALLY, that such amendments shall, prior to the adoption thereof, have been approved by the Council of the California Medical Association evidenced by resolution thereof.

C.M.A. Woman's Auxiliary—Annual Meeting

At this year's annual session of the California Medical Association, to be held in Los Angeles on May 7-May 10, 1946, the Woman's Auxiliary to the California Medical Association will convene in annual meeting. In due course, information will be sent to Component County Units.

CALIFORNIA PHYSICIANS' SERVICE†

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* * *

Executive Staff

W. M. Bowman, Executive Director
A. E. Larsen, M.D., Medical Director
W. H. Gardenier, M.D., Assistant Medical Director

Veterans' Administration Program of California Physicians' Service

California Physicians' Service has been nationally honored and recognized for the work that it has done in the field of prepaid medical care, through the signing of a contract with the Veterans' Administration. The purpose of the contract is to provide medical care for our veterans in their home communities for service-connected disabilities. (For editorial comment, see page 63.)

The problem of providing adequate medical care to our vast numbers of returning veterans, has been recognized by the Veterans' Administration, as one of the greatest jobs it has been called upon to handle. The existing veteran facilities and personnel have been recognized as inadequate, and the situation has been of national interest. After a Congressional investigation, the Surgeon General indicated that public criticism of this condition had some justification, and gave the responsibility for remedying the defects to Major General Paul R. Hawley. General Hawley is eminently qualified for the work as his past record as Chief of Medical Services in the European theatre of war was one of distinction.

In a realistic approach to the situation General Hawley has secured the aid and services of existing medical service plans. In California, the California Physicians' Service had already developed the administrative structure for the eventual care of the greater part of the states population, and had formal agreements with more than 6,000 physicians; thus, it was a logical organization to assume the responsibility for supplementing the needs of the Veterans' Administration.

It was the express opinion of the officials in Washington, that they desired to work through organized medicine. After lengthy negotiations, considering the aspects of the Veterans' Administration Act, California Physicians' Service developed a contract which has been approved by General Hawley.

The overall contract provides for the care of veterans, for service incurred disabilities, in their home communities. It places veterans in California who otherwise would be cared for through government agencies, under the care of private physicians who are members of C.P.S. The physician who renders treatment or makes examinations will be paid by the California Physicians' Service at the full par unit value of its established fee schedule. California Physicians' Service will in turn then bill the Veterans' Administration for reimbursement of the funds expended. The contract provides for funds, allotted over and above the fee schedule to care for administrative expenses.

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† Address: California Physicians' Service, 153 Kearny Street, San Francisco, Telephone EXbrook 0161.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization through W. M. Bowman, Executive Director.

It is the express desire of the Washington office, and also of the Regional Offices of the Veterans' Administration, that the operations of the plan should be worked out as quickly as possible, with the elimination of as much red tape as possible. Emphasis has been placed on the simplification of procedures, so as not to inconvenience the physicians, or the veteran. Old, established procedures that have been used by the Veterans' Administration for many years have been discontinued completely, in the interest of achieving this objective. Thus, the responsibility of developing a smooth and simple administrative plan will fall upon California Physicians' Service, in coöperation with the Veterans' Bureaus. The experience gained by California Physicians' Service over its seven years of operation in designing administrative techniques of caring for large numbers of people should prove invaluable.

The American Legion, which was a staunch ally of C.P.S. in opposing compulsory health insurance during the past legislative hearing, is vitally interested in the program, and has expressed a desire to work closely with C.P.S., as the plan develops.

Following the example of California and Michigan, who signed contracts almost simultaneously other states in the union should follow rapidly, using much the same pattern developed by these two plans. Thus, there will be developed, in a relatively short period of time what may be termed almost a national health program.

We have accepted the responsibility with confidence that our training and experience in this field will prove satisfactory to the Veterans' Administration, and the veteran.

Respectfully submitted,
Wm. M. Bowman, *Executive Director,*
California Physicians' Service.

California Veterans Will Get Home Town Medical Care Through C.P.S.

Washington, Jan. 9.—(AP.)—The Veterans' Administration and medical men announced last night that California ex-soldiers will get home town medical care. It is the second such Statewide plan.

The new system was inaugurated by a Michigan contract with a physicians' organization 10 days ago. California has 1,350,000 veterans.

Cites Doctor Shortage

General Paul R. Hawley, chief medical director of the administration, told reporters the plan is necessary because the agency has not enough doctors. Approximately 90,000 veterans already are getting care in government institutions.

The plan also will permit the men to receive treatment for their service connected disabilities in their home towns from their own physicians without having to travel to distant medical centers.

Ex-servicemen personnel of both World Wars and the Spanish-American War are eligible, explained Mr. W. M. Bowman, executive director of the California Physicians' Service, associated with the California Medical Association.

Under the plan, Mr. Bowman told reporters, the physicians' services are paid for by the Veterans' Administration according to a set fee schedule of prevailing rates.

It works like this: A veteran may apply to his doctor or the Veterans' Administration in his own town. The latter decides if the injury comes of military service. If so, the veteran's physician may treat him. The bill goes to the Physicians' Service, a nonprofit, prepayment organization. It collects the doctor's fee from the Veterans' Administration and sends it to him.—Sacramento *Bee,* January 9.

Letter From Major General Paul R. Hawley

(copy)

Veterans' Administration
Washington 25, D. C.
Department of Medicine and Surgery

January 15, 1946.

Dr. George H. Kress, Secretary-Editor,
California Medical Association,
2004 Four-Fifty Sutter,
San Francisco 8, California.

Dear Dr. Kress:

Thank you for your letter of 9 January enclosing the item from the "San Francisco Chronicle" and the advance proof of an editorial appearing in the January issue of your publication.

I am very appreciative of the coöperation tendered us by the California Physicans' Service and feel sure that they will aid materially in giving good medical attention to the veterans.

With kind regards, I am,

Sincerely yours,
(Signed) P. R. Hawley,
Major General, A.U.S.,
Acting Chief Medical Director.

Montana Organizes a Volunteer Health Insurance Plan

Montana physicians have set in motion plans for a low cost, voluntary health insurance program patterned after the California Physicians' Service, according to Dr. C. L. Cooley, secretary of the board of trustees of C.P.S., who has returned to California after a meeting in Butte, Montana, where he outlined the success of the California plan to the members of the Montana State Medical Association.

An explanation of California's prepaid medical plan, he said, resulted in the decision to start operation of the Montana Physicians' Service on March 1.

"Montana's physicians were attracted to the California plan," said Dr. Cooley, "because of the great growth of the voluntary health program in our State. It is a recognition of the soundness of the voluntary system as against compulsion or State medicine."

William Bowman, executive director of C.P.S., who accompanied Dr. Cooley, was authorized to contract with the Veterans' Administration for medical care of Montana veterans. The agreement, it is understood, will be identical with the one Mr. Bowman recently arranged for California. Starting on February 1, it provides veterans with home-town medical care at government expense for service-connected disabilities which do not require hospitalization, with the right to choose their own doctors.

Aimed at slashing red tape and eliminating delays, the service will be available to participants of World Wars I and II and the Spanish-American War.

Sam English, manager of the California Physicians' Service San Diego office, has been named Montana director.

Fee Schedule V.A.-C.P.S.—Fee schedule of V.A.-C.P.S. may appear in the March issue of California and Western Medicine.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Refresher Training for Doctors Leaving Service

Refresher training of 12 weeks' duration will be given Army doctors leaving the service who desire to brush up on latest developments in fields of medicine, surgery, or neuropsychiatry in which they may not have been actively practicing during the past year, Major General Norman T. Kirk, Surgeon General of the Army, recently announced.

This training, which will prepare retiring Army doctors for return to private practice with latest knowledge of medical advances made during the war, will be given at Army hospitals until June 30, 1946. Reserve Corps, National Guard, and A.U.S. Medical Corps officers who are to be separated will be eligible for this schooling.

The election of the period of refresher training is entirely voluntary, and applications may be made through channels to the Surgeon General in the case of medical officers assigned to the Army Service Forces, Army Ground Forces and Army Air Forces. Medical officers returning from overseas may make application for refresher training from the Reception Stations or Separation Centers through the A.S.F. Liaison Officer directly to the Surgeon General. It is pointed out that medical officers cannot be recalled to active duty from terminal leave for the purpose of accepting a professional assignment for refresher training.

Numerous requests have been received by the Surgeon General from Reserve Corps, National Guard, and A.U.S. Medical officers who are about to be separated and who desire to remain in service for a short period of professional duty prior to return to civilian life. These officers are anxious to return to their civilian practices with the advantages of the latest medical knowledge. Due to the tremendous demand for refresher training placed upon civilian medical teaching centers, many of these medical officers have been unable to arrange for refresher training.

The Surgeon General emphasizes the fact that the refresher training is accomplished by a 12-week temporary duty assignment in the professional field of interest at an Army hospital without per diem. Such an assignment will afford the medical officer a period of clinical work under supervision, and excellent opportunities for collateral study of recent advances in medicine, surgery, and neuropsychiatry.

(Ed. Note.—For additional information concerning courses available in California, see in this issue in department of Committee on Postgraduate Work on p. 96.)

Army Will Call 5,000 Young Medical Officers to Duty

More than 5,000 young medical officers trained under the army specialized training program will be called to active duty July 1st to replace medical corps officers eligible for discharge, the war department announced on January 8.

The A.S.T.P. graduates are now taking internships and occupying residencies in civilian hospitals. After July 1st they will not be continued on inactive status for these purposes.

Notice has been sent to the hospitals where they are training so they may make arrangements for replacements.

Approximately 3,300 enlisted men now assigned to A.S.T.P. units for medical training will receive their doctors' degrees by July 1, 1946, when the A.S.T.P. medical program will be discontinued. This group will be called to active duty upon completion of internships.

Enlisted men now taking freshmen, sophomore and junior medicine will be separated from the program in March. Those who plan to continue medical studies will be transferred to other military duties and continue on active duty until eligible for separation.

More than 4,500 medical officers now serving with the medical department of the army were trained as enlisted men under the A.S.T.P. A small number of A.S.T.P. graduates with physical defects barring them from service with the armed forces as medical officers have been assigned to the Veterans' Administration.

On: Problems Related to Return of Military Colleagues to Civilian Status

To: U. S. Army, Procurement and Assignment Service, and Others Concerned.

From: C. R. Bird, M.D., Indiana Chairman, Procurement and Assignment Service, 1021 Hume Mansur Building, Indianapolis 4, Indiana.

Subject: *Reply to Communication from a Group of Overseas Medical Officers*

1. The enclosed condensed copy of a letter was received from a group of medical officers in the E.T.O. Because of its wide distribution and for the purpose of clarification, it calls for a reply.

2. The Army is not concerned with socialized medicine. The people will decide that issue. Of real concern is the fact that doctors released from service are not returning to former locations in smaller towns. Young men wish to qualify for one of the specialty boards and will locate in larger centers. If the profession does not meet the need of rural communities, it will be met for us by unfriendly agencies.

3. It is impossible to decide from a remote sector of the world what the policies of the Surgeon Generals' Office shall be, for this requires experience and an overall knowledge.

4. Medical Officers as a group cannot be singled out for priority; there are thousands of officers in other branches, and tens-of-thousands of G.I.'s who also want to get back to the United States. Many factors enter into demobilization, not the least of which is transportation. Ships are loaded to the guard rails; port facilities are taxed to the point of saturation; railway transportation exhausts its every facility; every railway station across the nation is jammed. The Army is doing a splendid job of demobilization, notwithstanding being hounded by the people, the press, and the Congress. During the month of December 1,500,000 men will be returned to the United States. All physicians over 48 are due for immediate release; all with 70 points, and all with 42 months of service (with the exception of certain specialists) are eligbile for release within 90 days from December 1, 1945. It is not *true* that those within the United States are shown favoratism. By July 1, 1946, only 11,000 doctors will remain in service. By January 1, 1946, twenty-three of the sixty-five general hospitals in the U. S. will be closed.

5. Hundreds of military installations throughout the world must be staffed. The 27 separation centers must have several thousand medical officers for examinations and review boards.

6. *The most severe criticism that could be directed toward the Army would be for neglect of the sick and wounded.* The peak of this load was 318,000. They must

remain in hospitals until maximum improvement has been attained.

7. All A.S.T.P. and V-12 trainees and all other eligible graduates in medicine will be on active duty by July 1, 1946.

Mortality Rates of Physicians in Active Military Service

Death Claimed Approximately 4,015 Doctors As Compared With 3,415 During '44; Heart Disease Leading Cause

Death claimed approximately 4,015 physicians during 1945 as compared with 3,415 the previous year, according to the January 19 issue of *The Journal of the American Medical Association.*

On the basis of an analysis of 2,962 obituaries published in *The Journal* during the year, it was found that the average age at death was 65.3, the same as in 1944. The majority of the physicians—494—died between the ages 70 and 74.

Heart disease continued to lead the causes of death among physicians. Coronary thrombosis and occlusion accounted for 655 deaths, 246 occurring between the ages 60 and 69. Cancer and tumors accounted for 296, and pneumonia claimed 145 doctors.

Of the 25 suicides recorded, 11 were the result of bullet wounds, three of a cut artery and three of drugs. There were 87 accidental deaths and 33 of them involved automobiles.

Among the decedents were 256 who had been teachers in medical schools, of whom 97 had reached professorial status. There were eight deans, one of whom had also been president of a medical college, two principals of a high school, two teachers in public schools, one of whom had been head of the business and practice department of the city's high schools, and 78 members of education boards. One hundred and forty-four had been health officers.

The 2,962 *Journal* obituaries included 116 physicians who were killed in action during World War II and 118 who died while in military service. Nineteen physicians lost their lives in the Pacific area, 13 in Germany, 12 each in the European Theatre of Operations and in France, and 11 in Okinawa, including six who were lost in the attack on the *Comfort.*

Of the 118 physicians who died while in military service, aircraft accidents caused the deaths of 22 and vehicle accidents of 10. Heart disease accounted for 25 deaths, 12 of which were attributed to coronary thrombosis. Cancer caused 13 deaths.

The 116 deaths classified killed in action give an average age of 33.0, while the 118 who died while in military service average 40.1. By combining the two, an average age of 36.6 is noted.

Of the seven U. S. Public Health Officers whose deaths were recorded, one died when he slipped on the Jacob's ladder while assisting wounded aboard ship and one when his ship was destroyed by enemy action.

Fourteen More Army Hospitals to Close by March 31, 1946

Fourteen additional Army General Hospitals, three annexes to General Hospitals and four Convalescent Hospitals will be closed by March 31, 1946, according to present Army Medical Department plans, Major General Norman T. Kirk, Surgeon General of the Army, has announced.

In accordance with the Surgeon General's policy of releasing these hospitals as rapidly as the decrease in the patient load justifies, these units will be offered to the Veterans' Administration or else reported to the Surplus Property Administration for disposal.

Out of a wartime peak of 65 General Hospitals operated by the Army Medical Department, 20 have already been closed. In addition, out of a peak of 13 Army Service Forces Convalescent Hospitals, three have already been closed.

The closing of these fourteen General Hospitals, three annexes and four Convalescent Hospitals will result in a reduction of approximately 38,000 beds in General Hospitals and 6,500 in Convalescent Hospitals.

After the evacuation of all transportable cases from overseas theaters there were approximately 121,400 patients in Army General and Convalescent Hospitals at the first of the year. It is estimated that there will be approximately 39,700 on June 1, 1946. The peak patient load in Army hospitals in the United States was reached in August, 1945, with a total census of 315,000.

There will be a lapse of sixty days between the dates on which the hospitals will be closed and the dates on which they will be declared surplus to the needs of the War Department, in order to allow time for handling transfer of property and other administrative details.

Department of Medicine and Surgery in the Veterans' Administration

With the signing of H.R. 4717 by the President, now Public Law 293, there was created in the Veterans' Administration a Department of Medicine and Surgery under a Chief Medical Director. General Bradley announces that he has designated General Paul R. Hawley to serve as Acting Chief Medical Director. This act will bring professional personnel into an organization comparable with the Army and Navy Medical Corps and the U. S. Public Health Service.

General Bradley immediately authorized the employment of physicians, nurses and dentists to fill existing vacancies. There is an immediate need for 1,125 doctors, 1,200 nurses and 100 dentists.

Among the major provisions are:

1. Specialists certified by V.A. will be paid 25 per cent more salary up to a ceiling limit of $11,000 a year.

2. Residencies will be set up in V.A. hospitals where younger doctors may study to qualify as specialists. This will mean that veterans will be able to obtain the most up-to-date medical treatment—the same kind as if they were admitted to hospitals connected with the nation's leading medical schools and centers.

3. Promotions will be made on recommendations of special V.A. boards which, in general, compare with the "selection boards" operating in the Army and Navy for higher ranking officers. . . .

6. Appointments of key executives will be for a four-year term, subject to removal by the Administrator for cause. Reappointment will be for the same term.

7. Doctors, dentists, nurses and technicians now employed by the V.A. will be continued on their present jobs pending determination of their qualifications for appointment in the new medical department.

8. Another provision of the act which will permit professional improvement of V.A. medical presonnel will allow up to five per cent of such employees to study or do research work for periods of time up to 90 days. This will enable doctors, dentists, nurses and technicians to attend recognized schools or work with the U. S. Public Health Service or other research groups. Officials pointed out that this would enable workers to keep abreast with the very latest developments in their respective fields.

9. Although they are not subject to selection or promotion by Civil Service, the members of the new V.A. Department of Medicine and Surgery will be under the Civil Service Retirement Act of 1920 and will receive its benefits.

General Hawley commenting on the President's action said:

"With the signature of the medical department act, our objective is clear—a medical service for the veteran that is second to none in the world. Around the splendid nucleus of excellent men and women in the V.A. medical service, we shall build such an outstanding service."

Veterans' Administration Hospitals in California

In reply to a request from the Editor of CALIFORNIA AND WESTERN MEDICINE, Col. James G. Donnelly (M.C.), manager of Veterans' Administration, San Francisco 21, has sent the following information:

"This will acknowledge receipt of your communication of January 3, 1946, in which you request information as to the location of the Veterans' Administration hospitals in California. The following is a corrected list:

Veterans' Administration Hospital, Palo Alto (Neuropsychiatric), Col. P. G. Lasche, Manager.

Veterans' Administration Hospital, Livermore (Tuberculosis), Lt. Col. F. G. Bell, Manager.

Veterans' Administration Center, San Francisco (General Medical and Surgical), Col. James G. Donnelly, Manager.

Veterans' Administration Hospital, San Fernando, (Tuberculosis), Dr. S. H. James, Manager.

Veterans' Administration Center, Los Angeles (General Medical, Surgical, Neuropsychiatric, and Domiciliary), Col. R. A. Bringham, Manager.

Home Town Medical Care for Veterans

The sensible and economical home medical service guaranteed to California veterans through agreement between the Veterans' Administration and California Physicians' Service adds to the debt of gratitude the American people owe Veterans' Administrator General Omar N. Bradley.

He is an administrative genius who knows what he wants for the veterans—and gets it. He forced long-needed service reforms in veterans' hospitals. He put an end to political log-rolling in the building and locating of hospitals. And the problem he has licked with the coöperation of California doctors was a knotty one. This state already has 1,300,000 ex-service men and women. Of World War II veterans, nearly 70 per cent claim service-connected disabilities. The great majority are not ill or incapacitated enough to require separation from their homes and jobs in veterans' hospitals, but do need the best in medical service as out-patients, and are entitled to it without delay, red tape or personal cost.

The problem has been solved simply and permanently. After February 1, any veteran determined eligible by the Administration for out-patient care at government expense may go to any C.P.S. doctor for treatment. The doctor will be paid on the basis of a fee schedule set up in the contract between C.P.S. and the Administration.

There are C.P.S. medical men in every community. It is due to the progressiveness of the California Medical Association, which pioneered the field of voluntary prepaid medical care by organizing and financing California Physicians' Service, that the type and standard of health service sought by General Bradley was in readiness in this State.

Undoubtedly the California program will be a pattern for national emulation. Every veteran whose physical well-being was impaired in the service of this country is certainly entitled to the finest of medical care. And California is indeed fortunate that this service can be provided on a home-town basis, without government regimentation of either the veteran or the medical profession.—Anaheim *Bulletin*, January 17.

Appointment of Medical Department Officers to the Regular Army

The Surgeon General believes that all Medical Department officers, now on active duty, and those who have been released from the service, will be deeply interested in the provisions of Public Law 281 which provides for the procurement of additional male officers and their integration into the Regular Army. It is hoped that earnest consideration will be given to a career in the Medical Department of the Regular Army by all eligible officers. The provisions of Public Law 281 coupled with the postwar plans for the Medical Department provide for an extremely attractive career with outstanding opportunities for professional advancement, as well as a secure and interesting life.

Some Medical Corps officers have, in the past, been assigned to administrative duties and this has been the most repeated objection to a career in the Regular Army for physicians. The Surgeon General realizes this fact and believes that most physicians are chiefly interested in the practice of medicine. Therefore, policies have been established in an effort to improve the professional medical possibilities involved in a career in the Regular Army Medical Corps.

It is believed that Public Law 281, as recently enacted, offers the necessary inducements for the procurement of desirable Medical Department officers. With the present group of Regular Army Medical Department officers and those made available by the enactment of Public Law 281, the Surgeon General believes that the policies outlined above will allow him to implement his postwar plan for the Medical Department with a resultant highly trained group of professional and administrative officers who will maintain the high standard of medical care which has prevailed during the war.

War Department Circular 392, dated December 29, 1945, prescribes the provisions and procedures with regard to application for and an appointment in the Regular Army.

Applications will be submitted in the following manner: Applications will be submitted so as to reach the Adjutant General's Office, Washington 25, D. C., *not later than March 1, 1946*. Applications must be made on WD AGO Form 62, 1 November 1945. These forms can be obtained from any Army unit or installation headquarters. Applications received by the Adjutant General, Washington 25, D. C., after March 1, 1946, will not be considered. A formal application will be required regardless of whether or not a statement of interest or other form of application has been submitted previously. Each application will be prepared in duplicate.

Advantages of Army Careers for Doctors

The advantages of an Army career for doctors and other officers who are appointed members of the Medical Department under the new law authorizing additional officers for the Regular Army were stressed recently in a statement by Major General Norman T. Kirk, the Surgeon General of the Army.

Under the terms of this recently enacted law, doctors who apply for appointment and meet the requirements will be given commissions in the grades of First Lieutenant, Captain and Major.

The Army expects to attract a competent staff of doctors who will maintain the high standards which have prevailed during the war in the care of the sick and wounded because there are definite advantages for the professional man who elects to serve in the Army, according to General Kirk.

A professional career offering broader possibilities in a larger field than the practice of the average civilian doctor affords is open to the Regular Army Medical Corps Officers, General Kirk pointed out. The policy of the Surgeon General of making all general hospital centers for certain types of cases and specialty training gives the doctors in those centers exceptionally wide and varied experience.

The Army has been and is now conducting residency-type training which will allow and encourage doctors to advance in their professional qualifications. Opportunities for administrative and field training will also be continued.

It is the policy of the Surgeon General to arrange the training and assignments of Army doctors in a way to help them obtain board certification for specialties from recognized civilian specialty boards. Army fellowships, residencies and special courses are in operation to further this program designed to aid in advancing the personnel of the Medical Department from a professional standpoint. As facilities and opportunity permit, training in recognized civilian institutions will be expanded.

The program of graduate medical education and research for Medical Corps officers can be ascertained in more detail from recent publications of the Office of the Surgeon General or by direct communication to the Director, Educational and Training Division, Office of the Surgeon General.

The security assured the Army doctor will appeal to many professional men, the General explained. There is regular income and regular promotion and also retirement pay, which amounts to 75 per cent of base plus longevity pay for the doctor who has served 30 years or who has reached the statutory age limit. If a man is retired for physical disability at any time during his Army career, he will also receive 75 per cent of his pay at time of retirement for the rest of his life. The Army doctor and his family are also eligible for medical care and hospitalization.

The opportunity to serve in foreign countries will appeal to those who are interested in travel. Wherever there are American forces overseas there will be members of the Medical Department to look after the health of the Army.

Under the new law, any doctor, physically and professionally qualified, who has been on active duty in the Army since Pearl Harbor, and who is under forty-five years of age, is eligible for appointment in the Regular Army, unless he has been separated from the service under other than honorable conditions.

The Adjutant General will direct the applicant to a personnel center where he will be given a physical examination and a general survey test and will be interviewed by a board of officers.

Applications must reach the Adjutant General's office, Washington 25, D. C., not later than March 10, 1946. A formal application made on WD AGO Form 62, 1 November 1945, will be required even if a statement of interest or other form of application has been submitted previously.

Application WD AGO Form 62 can be obtained at any Army installation or unit headquarters or upon written request to the Adjutant General's Office, War Department, Washington 25, D. C.

The applications should be in duplicate. A person on active duty should submit the application in duplicate through his immediate commander. Those not on active duty should apply direct to the Adjutant General, War Department, in Washington, D. C., Attention AGSO-R. Anyone outside the United States should send his application to the Commander of the Theater in which he is located.

Further Army Criteria Reductions for Physician Members of Medical Corps

Further criteria reductions to make additional doctors, dentists and veterinarians available for civilian practice were announced on December 31, 1945, by Major General Norman T. Kirk, the Surgeon General of the Army.

While the number of professional men affected by this action will not be more than a thousand, the Surgeon General's Office has ordered this revision of criteria in line with the Medical Department's policy of doing everything possible to expedite the return of doctors, dentists, and veterinarians to private life.

Under the new separation plan which became effective January 1, 1946 (with the exception of a comparatively small number in scarce categories) dentists, and veterinarians will be released with a critical score of 65 instead of the 70 points previously required. This same group will also be able to get out of the service, if the age of 45 has been reached instead of the former age limit of 48.

The time factor of 42 months service, which will make any of this group eligible for separation, remains the same.

The following specialists in scarce categories will be released with a critical score of 80, continuous service since Pearl Harbor, or if the age of 45 has been reached: Eye, ear, nose specialists; orthopedic surgeons; and internal medicine specialists.

A requirement of 70 points, 45 months service, or 45 years age limit will make the following eligible for separation: gastroenterologists, cardiologists, urologists, dermatologists, anesthetists, psychiatrists, general surgeons, physical therapy officers, radiologists, and pathologists.

Plastic surgeons will be eligible for release if they have a critical score of 80, or service since Pearl Harbor, or if they are 48 years of age.

Army Institute of Pathology—Army Medical Museum

The Army Institute of Pathology is the central laboratory of pathology for the entire United States Army. It comprises four departments: the Laboratories of Pathology, the American Registry of Pathology, the Army Medical Illustration Service, and the Army Medical Museum. These four departments are administratively coördinated by the Director, who is a colonel in the Medical Corps of the Regular Army. The professional staff consists of more than twenty officers who have been selected on the basis of specialized knowledge. Technical and clerical aid is rendered by a detachment of 30 enlisted men and WACS and 62 Civil Service employees.

The Institute, a division of the Surgeon General's Office, is housed, together with the Army Medical Library, at Seventh Street and Independence Avenue, S.W., Washington, D. C. The present building, erected in 1887, being no longer adequate for the needs of either organization, plans for new and separate buildings are now being prepared.

The Army Institute of Pathology has three principal functions:

a. It furnishes a consultation service for the diagnosis of pathologic tissue for the entire Army;

b. It conducts investigation and research on diseases of medico-military importance;

c. It supplies instruction in pathologic anatomy to Medical Department officers.

General Lull Leaves U. S. Army (M.C.) to Become Associate Secretary and General Manager of American Medical Association

Major General George F. Lull, Deputy Surgeon General of the Army, whose notable record in that capacity won him the Distinguished Service Medal, the highest noncombatant award, has retired from the Army after 33 years of service with the Medical Corps.

General and Mrs. Lull will move to Chicago, where General Lull will become Associate Secretary and General Manager of the American Medical Association. He will take up his new duties officially in July, when the retirement of Dr. Olin West, the present Secretary and General Manager, becomes effective, but he will immediately join the staff of the American Medical Association to familiarize himself with the work of the organization.

The citation for the Distinguished Service Medal stated that, in his capacity as Chief of the Personnel Service, General Lull was largely responsible for the development of policies and studies which resulted in outstanding achievements in the Army's medical program.

Early in World War I, he commanded a base hospital at Camp Beauregard, Louisiana, and later organized and commanded Base Hospital No. 35 of the A.E.F. From 1922 until 1926 General Lull was Director of the Department of Preventive Medicine at the Army Medical Center. In 1929 he was appointed Medical Adviser to the Governor General of the Philippine Islands, where he served for three years. He had charge of the Vital Records Division of the Surgeon General's Office from 1932 to 1936.

The following four years he was Director of the Department of Sanitation at the Medical Field Service School, Carlisle Barracks, Pennsylvania. In 1940 he returned to the Surgeon General's Office as Chief of Personnel Service until May 31, 1943, when he was appointed Deputy Surgeon General.

Born in Pennsylvania March 10, 1887, General Lull received his M.D. degree from Jefferson Medical College in 1909, a Certificate of Public Health from Harvard Technology School of Public Health in 1921, and his degree of Doctor of Public Health from the University of Pennsylvania in 1922. He is an honor graduate of the 1913 class of the Army Medical School.

U. S. Public Health Service: Vacancies in Reserve Corps

Appointments to fill vacancies in the Reserve Corps of the United States Public Health Service are now being made, and examinations for Regular Corps appointments will be held in April and May, Surgeon General Thomas Parran announced on January 17, 1946.

Physicians, dentists, and nurses are needed immediately for duty in hospitals, in the Tuberculosis and Venereal Disease Control programs, and in other activities of the Public Health Service.

Pay and allowances, established by law, are identical with those for medical officers of the Army. All travel expenses, including travel to first station, are paid by the Service.

Appointments to the Reserve Corps are made on a basis of review of data furnished by the applicant. Physical examination is required.

Regular Corps appointments require appearance before a Board, and a written professional examination. Dates and places for the examination will be announced shortly.

The Service pointed out that a person receiving an appointment in the Reserve Corps immediately, may, if he desires, take the examination for the Regular Corps at the time they are held.

Those interested in either immediate appointment in the Reserve Corps, or in taking the examination for the Regular Corps, should request application forms of the Surgeon General, U. S. Public Health Service, Washington, D. C., Federal Security Agency.

Military Clippings.—Some news items of a military nature from the daily press follow:

Staffs of Veterans' Administration (VA) Hospitals Undergoing Reorganization

Washington, Jan. 9.—(INS.)—General Omar Bradley, head of the Veterans' Administration, officially disclosed today that a wholesale weeding out of "incompetent" doctors in veterans' hospitals is under way.

General Bradley and Maj. Gen. Paul R. Hawley, Veterans' Administration medical director, said the "house cleaning" process was started immediately after President Truman signed the bill removing Civil Service restrictions from the administration's medical setup.

Hawley said physicians and surgeons of unquestioned ability are now being employed through Washington headquarters and assigned to key posts in the ninety-seven veterans' hospitals in operation.

They are being instructed to observe closely the qualifications of present staff members, to make recommendations as to dismissal or retention, submitting lists of incompetents to Generals Bradley and Hawley for final action.

Hawley estimated the program would take approximately a year to complete.

Hawley said he could not estimate the number of physicians who might be ousted as a result of the survey but cited as an example one instance in which nineteen members of a staff of ninety doctors at one hospital had been recommended for dismissal.

Bradley emphasized that capable physicians now serving in veterans' hospitals need have no fear that they will be dismissed.—San Francisco *Examiner,* January 10.

War Casualties 1,068,378

Army Reports 223,215 Killed; New Report

Washington, Jan. 28.—(AP.)—The War Department revised upward today its wartime casualty list, adding 5,646 to the list of soldiers killed, and bringing the overall total of all American casualties to 1,068,378.

The War Department report, corrected to December 31, listed total Army casualties as 922,764, an increase of 109 over the last previous total announced two months earlier.

Compared with the November 1 report, the principal change was to increase the list of those killed from 217,569 to 223,215, while reducing the number missing from 18,311 to 12,752.

The latest computation for the Navy, Marine Corps and Coast Guard lists 145,614 total casualties, including 59,678 killed, 80,279 wounded and 5,657 missing.

Okinawa Was Costly Fight, 79,507 Casualties Recorded

Washington, Jan. 8.—The battle for Okinawa cost the United States forces a total of 79,507 casualties, it was disclosed today. Total enemy casualties were estimated officially to have amounted to 120,000, or a ratio of about three to two.

The new figure of nearly 80,000 casualties is to be compared with the total of 45,029 reported by Fleet Admiral C. W. Nimitz on June 21 at the time enemy organized resistance was declared to have been broken.

The revised total, based on Army, Marine and Navy records, includes killed, missing, wounded in action and the so-called non-battle casualties.

It is the public addition of the non-battle casualties which has boosted the total so high.

Included in the 32,473 Marine and Army casualties, listed as non-battle, were a large number of "combat fatigue" cases, which were, in fact, the result of battle.

Front-line correspondents reporting the battle of Okinawa were aware of the large number of non-battle casualties suffered in the fighting for that island, but their attempts to report them to the public at a time when the island was in the news were prevented by Admiral Nimitz's censors. Navy controlled censorship limited reports to the total casualties reported in Admiral Nimitz's communique.

The new total includes 21,342 Army, 16,313 Marine and 9,721 Navy battle casualties.

Non-battle casualties totaled 21,592 for the Army and 10,881 for the Marine Corps.

On the basis of these figures, it now is clear that the battle for Okinawa was the toughest, costliest single engagement of our offensive campaign in the Pacific.—San Francisco *Chronicle,* January 9.

Mars Presents the Bill

Except in astronomical computations, the figure "trillion" has been mostly theoretical on this planet, but our subtrillion days are behind us.

The Bank of International Settlements at Basle has placed the direct costs of the recent war at roughly 680 billion dollars. When to this tidy sum is added property losses, lost production, the cost of war relief and neutrals' losses, to say nothing of the inestimable value of human life and of the future production lost through death, we see that we have climbed to the trillion class.

One of the Pharaohs once amassed an unprecedented war chest of silver—valued at $4,000,000. The Napoleonic wars have been estimated to have cost $1,500,000,000. Our Civil War cost about $5,000,000,000. The First World War, revaluating the 1913 dollar to compare with 1945, is placed at $180,000,000,000.

Nor can any given sequel be dissociated from the costs of wars. Authorities on the French Revolution say that the deficit financing occasioned by the necessity to meet loans which had financed the Thirty Years' War and adventures of Louis XIV was an important factor in the widespread poverty which resulted in the Revolution. Thus, the bill for war, as huge as it has become, is not necessarily paid when the last bond is retired; the strain of paying often leads to more payment in the form of depression, inflation and social revolution.

If another world war would cost three trillions, there is no way of figuring how such a sum could be raised except by so total a lien upon future generations as to make it impossible for them to carry the burden and maintain a free society.—San Francisco *Chronicle*, January 12.

Medical Information Disseminated by Micro-Film

The Army Medical Library's system of broadcasting current information by means of micro-film prevented many countries in various parts of the world from being blacked-out from a standpoint of the latest medical and surgical knowledge, according to a statement released by Major General Norman T. Kirk, the Surgeon General of the Army.

Millions of pages of medical literature revealing the latest developments during the war were furnished to isolated posts and occupied countries by means of this miniature method of reproduction, to keep American and Allied and other doctors abreast of advances being made in Army practice.

The secrets of the use of the miracle drugs, penicillin and the sulfas, which were developed in this war, would have remained unknown to large portions of the world, if it had not been for the dissemination of such information through micro-film, General Kirk said.

Untold numbers of lives have been saved as a result of this worldwide plan of broadcasting new discoveries and techniques in saving the lives of the American and Allied sick and wounded located on isolated posts, as well as of people in occupied countries.

Representatives of the Rockefeller Foundation and other similar organizations reported that after the Japs closed the Burma road, China would have been in almost total darkness as far as knowing the progress that was being made during the war years in the field of surgery and medicine, if it had not been for this micro-film plan.

Colonel Leon L. Gardner, Director of the Army Medical Library explained that it would have been impossible to send out the hundreds of tons of literature covering all the various phases of medical advances being made in this war. However, by a system of selection, the significant material was reduced to micro-film and broadcast to all parts of the world.

Mr. Cosby Brinkley, Chief of the Army Medical Library's Photographic Duplication Service, who has been largely responsible for the development and management of this service, said that the entire material contained in about fifteen medical journals can be reproduced on one 100 foot roll of 35-millimeter film, which weighs only 8 ounces. When ready for shipping, this roll measures 3½ inches in diameter and 1½ inches in thickness.

Professional men who received these films used ordinary photographic enlargers, or some type of projection or viewing apparatus, to flash, in miniature page, onto some form of screen, so that the secrets of what was being learned by doctors in all parts of the world could be put to use by them.

High priority was given these rolls of micro-film, which were sent by air mail to American and Allied commanders of posts and hospitals and to key individuals in occupied countries. The State Department coöperated by transmitting some of these rolls in diplomatic pouches.

Mr. Brinkley said that from 40,000 to 60,000 feet of these micro-films were sent out monthly, which means that over 10,000,000 pages of medical literature a year was being flashed to scientists throughout all theaters of operations. In less than a day, he explained, a negative and sufficient positives could be made for complete coverage of the world-wide mailing list which the Army Medical Library built up.—Army *Bulletin*.

Points Cut for Discharge of Army Doctors

Washington, Feb. 1.—(UP.)—The Army today announced a reduction in discharge requirements for medical officers that will result in release of an additional 7,000 doctors and dentists within the next five months.

Those with 60 points, 39 months of active duty or who are 45 years old, will be eligible for discharge, effective immediately. This represents a cut of five points in the score and three months in length of service.

The reduced requirements, however, do not apply to about 800 scarce specialists who must have 70 points, 45 months of service or be 45. The score for specialists will be reduced to 60 on April 1. . . .

Meanwhile, the War Department revealed that Army Air Forces personnel has been reduced from a peak of 2,500,000 to 900,000. The Navy disclosed it can meet its peacetime goal of 500,000 enlisted men by next Sept. 1 without aid of the draft.—Los Angeles *Times*, February 2.

Veterans' Administration Needs in California

Sacramento, Feb. 6.—California entered the national Veterans' Administration controversy on February 6. . . .

The Upper House unanimously adopted a joint resolution by Senator Irwin T. Quinn, chairman of its military affairs committee. . . .

"California furnished 1,000,000 servicemen during this war, and there are now approximately 500,000 discharged veterans from other states residing here," Senator Quinn said. "A categorical check indicates there will soon be a million here who entered from other states, making a total of 2,000,000. This total is six times greater than after World War I and today we actually have only 350 more beds in permanent facilities than before the outbreak of World War II." . . . San Francisco *Examiner*, February 6.

Navy Reveals Secret Tests at U. C. of New Germ Weapon

A secret Navy medical team working at the University of California in Berkeley throughout the war demonstrated that a man-made epidemic as an instrument of war "is a likely possibility," a Navy announcement disclosed yesterday.

The announcement said the secret research also produced these findings:

1. Considerable knowledge was gained in mass defense against enemy use of an unnamed but deadly infectious disease.
2. Information was obtained which will be of great value not only in protection against bacterial attack, but also for control of communicable airborne diseases such as influenza in peacetime.
3. A protective suit was devised for workers in any prospective rescue or decontamination operation.

The research was carried on in the greatest secrecy by Naval Medical Research Unit No. 1 headed by Capt. Albert Paul Krueger, U.S.N.R., who in peacetime is a professor of bacteriology at the university.

Although declining to name the infectious disease which it was feared the enemy might use, the Navy said it is centuries old and one of the greatest of killers.

The researchers let it be known publicly they were studying means of preventing and controlling airborne infections, notably influenza. Behind this "blind" they carried on research against the deadly disease, proving first that it could be used effectively by an enemy and then seeking ways to combat it.

The research will continue, the Navy announced.—San Francisco *Examiner*, January 5.

Nips Return to Hiroshima

Survivors Lose Fear of City Blasted by A-Bomb

Hiroshima (Japan.)—Jan. 28.—Hiroshima, nearly consumed in the holocaust of the first atomic bomb last August 6, is being restored.

Slowly those who escaped that searing blast are beginning to edge back into the ravaged areas of this once bustling city of nearly 400,000.

In the past month each day has seen some family start rebuilding a bamboo, wood and plaster dwelling on the site of its former home.

The desolation caused when the atomic bomb destroyed

60 per cent of Hiroshima's 6.9 square miles of built-up area gradually is changing.

Most of the persons burned in the explosion have recovered or died, Col. John R. Hall, Jr., of El Paso, Texas, Tenth Corps surgeon, said today. He estimated that 47,000 were killed outright, 15,000 to 17,000 are missing and about 60,000 have died since the bombing from various contributing causes.

The survivors have lost their fear of the demolished region. They dreaded it at first because they didn't understand what had happened to them and their missing relatives.—San Francisco *Chronicle,* January 28.

V.D. Is Biggest Health Menace to Reich Troops

Berlin, Jan. 27.—Venereal disease is still far and away the biggest menace to the health of American troops in Germany, an unofficial survey disclosed today.

The incidence of V. D. among U. S. troops in Europe is averaging 200 cases per 1,000 men a year. In Berlin it is as big as 330 per 1,000. However, Paris appears to be a worse source of infection than Berlin. According to the records of the theater's Chief Surgeon, between October 5 and December 14, 1945, Paris accounted for 18.2 per cent of all new cases reported and Berlin only 4.1 per cent.—San Francisco *Chronicle,* January 28.

Veterans' Hospital Head Unmoved by "Pressure"

Washington, Jan. 27.—(UP.)—Political pressure has failed to budge Major General Paul R. Hawley from his determination to put veterans' hospitals where he thinks they belong, he said today.

Nor does he see any need so far, he said, to carry out his recent threat to resign as Veterans' Administration medical director. He had warned he would quit if political interference made it impossible to provide good medical care where it is most needed.

He declined to discuss a reported effort by Senator McKellar (D., Tenn.) to have him fired, or to comment on almost daily pressure from the Capitol to alter his hospital program.

But he promised:

"We will continue to take over surplus Army hospitals only where the need exists, and only where we can see prospects of staffing them adequately."

Hawley incurred congressional displeasure when he and Veteran Administrator General Omar N. Bradley turned thumbs down on most surplus Army hospitals because of temporary construction and remote location.

Some lawmakers also were irked when Hawley discarded construction plans of Brigadier General Frank T. Hines, Bradley's predecessor, and laid out a new building program based on availability of doctors as well as veteran population.—San Francisco *Chronicle,* January 28.

U. C., Stanford Medical Schools Will Help Vets

Stanford and California Medical Schools will coöperate with the Veterans' Administration in providing consultants and resident physicians for San Francisco's Veterans' Hospital.

Major General Paul B. Hawley, acting chief medical director of the agency, announced yesterday a committee from the two schools also will judge professional standards in the hospital.

Members of the committee from Stanford are Drs. Emile F. Holman, chairman; Arthur L. Bloomfield; George S. Johnson and Carleton Mathewson; California members are Drs. LeRoy C. Abbott, Karl M. Bowman, William J. Kerr and Howard C. Naffsiger.—San Francisco *Chronicle,* January 27.

Army Venereal Cases Increase

Washington, Dec. 1.—(AP.)—Sharp increases in venereal disease rates among American troops at home and abroad as fighting ended or diminished were reported today by the Army Medical Departments.

Official Figures

A report in the December bulletin of the Medical Department gave these figures:

In the European theater, the venereal disease rate rose from 62 cases per 1,000 men a year in May, (V-E month) to 155 in August.

In the Pacific area, the rate increased from five cases per 1,000 men a year in January to 97 in June.

"In the Pacific," the report said, "the marked increase in the rate occurred as the fighting in the Philippines diminished and there was more opportunity for exposure.

In the United States, the rate was 43 cases per 1,000 men a year in May and 53 in August.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

U. C. Course on Internal Medicine: For Military Colleagues

The Medical Faculty of the University of California will give a course on Internal Medicine for returning veteran physicians. The tentative program is as follows:

Although this is designed primarily for veterans, there will be opportunity for a limited number of general practitioners to attend. The course will begin on February 18, 1946, and will cover twelve weeks, every Monday evening from 8 to 10 o'clock.

PROGRAM OF POSTGRADUATE COURSE IN MEDICINE TO BE GIVEN IN TOLAND HALL, UNIVERSITY OF CALIFORNIA HOSPITAL, FROM 8 TO 10 O'CLOCK P.M.

General Chairman: *Stacy R. Mettier, M.D.*
Associate Professor of Medicine

1946—MONDAY EVENINGS

Feb. 18—*Dr. T. L. Althausen,* Associate Professor of Medicine, Chairman.
Diagnosis, X-Ray Interpretation, Medical and Surgical Treatment of Peptic Ulcer.

Feb. 25—*Dr. Leon Goldman,* Assistant Professor of Surgery, Chairman.
Diagnosis, Medical and Surgical Management of Diseases of the Gall Bladder.

Mar. 4—*Dr. John B. Lagen,* Assistant Professor of Medicine and Pharmacology, Chairman.
Peripheral Vascular Diseases.

Mar. 11—*Dr. William J. Kerr,* Professor of Medicine, Chairman.
Heart Diseases.

Mar. 18—*Dr. Robert B. Aird,* Assistant Professor of Surgery, Chairman.
Neurosurgical Symposium.

Mar. 25—*Dr. Herbert F. Traut,* Professor of Obstetrics and Gynecology, *Chairman.*
Obstetrical Medical Conference.

April 1—*Dr. James F. Rinehart,* Professor of Pathology and Medicine, Chairman.
The Pathologic Anatomy of Rheumatic Diseases.

April 8—*Dr. H. Clare Shepardson,* Associate Clinical Professor of Medicine, Chairman.
Diabetes.

April 15—*Dr. Mayo H. Soley,* Associate Professor of Medicine, Chairman.
Symposium on Goiter.

April 22—*Dr. Hans Lisser,* Clinical Professor of Medicine, Chairman.
Symposium on Endocrinology.

April 29—*Dr. William C. Deamer,* Associate Professor of Pediatrics, Chairman.
Symposium on Pediatrics.

May 6—*Dr. Hiram E. Miller,* Clinical Professor of Dermatology, Chairman.
Certain Dermatological Diseases.

* * *

Details of these programs will be announced later.

All speakers on the above programs are members of the Medical Faculty of the University of California.

Graduate Medical Education—School of Medicine University of Southern California

Extended and short courses in Internal Medicine, Surgery, and the various specialties are offered for returning medical officer veterans and for civilian physicians. Courses are conducted by the faculty of the Medical School, utilizing the facilities of the Los Angeles County

General Hospital, Children's Hospital, Barlow Sanitarium and other affiliated institutions.

Courses are open to all graduates of Grade A Medical Schools who have completed an approved internship.

Registration for all courses must be completed two weeks before commencement of course. Applicants for extended courses in Cardiology, Dermatology and Ophthalmology should communicate with Director, Graduate Division.

Tuition may be covered in part or full by the "G. I. Bill," Public 346.

All communications should be directed to: University of Southern California School of Medicine, Director, Graduate Division, 1200 North State Street, Los Angeles 33, California.

INTERNAL MEDICINE

Clinical Review of Internal Medicine:

Daily teaching ward rounds on the medical wards of the Los Angeles County General Hospital conducted by faculty members who are on the Senior Attending Staff of the hospital. Daily lectures, conferences and seminars covering recent advances in internal medicine and allied specialties.

Duration—12 weeks (full time).
Students—minimum 12—maximum 24.
Courses will begin Jan. 7, May 6, and Sept. 16, 1946.
Tuition—$250.00 (veterans $180.00).
Registration fee $5.00.

GENERAL MEDICINE

Clinical Review of General Surgery:

Students in groups of two rotate through General Surgery, Orthopedics, Malignancy, Gynecology, Urology, Proctology, Thoracic Surgery, Burns, Plastic Surgery and Neurosurgery. Ninety-eight didactic hours include a surgical review of Anatomy, Pharmacology, Pathology, Physiology and Radiology.

Duration—12 weeks (full time).
Students—minimum 12—maximum 24.
Courses begin Dec. 17, 1945, April 1, and Sept. 2, 1946.
Tuition—$250.00 (veterans $180.00).
Registration fee $5.00.

CARDIOLOGY AND VASCULAR DISEASE

(For Advanced Students)

The course is designed for 10 qualified physicians to engage in intensive study in the history, physiology, pathology, diagnosis and treatment of cardiac and peripheral vascular disease. Emphasis is placed on bedside teaching electrocardiography, fluoroscopy and associated diagnostic aids. The aim of the course is planned study to meet the requirements for certification by the American Board of Cardiology.

Duration—9 months.

DERMATOLOGY AND SYPHILOLOGY

Designed to meet requirements of the American Board of Dermatology for the academic year in preparation for certification. Courses will include Anatomy, Physiology, Biochemistry, Microscopic Immunology, Clinical Diagnosis and Treatment.

Duration—11 months.
Students—maximum 10.

OBSTETRICS AND GYNECOLOGY

Review of Obstetrics and Gynecology:

A. Gynecology—3 weeks—supervised study of gross and microscopic pathology daily, assist in out-patient and treatment clinics, attend ward rounds, lectures and surgical clinics.

B. Obstetrics—3 weeks—Analgesia and Anesthesia, X-Ray Pelvimetry, Toxemias, Hemorrhage, Abortions, Postpartum Infections and Operative Obstetrics will be covered in lectures and demonstrations. Daily rounds on wards, conferences, observation of deliveries and other operative procedures.

Duration—6 weeks (full time).
Students—maximum 10.
Courses begin Feb. 4, March 25, May 13, Aug. 5, and Oct. 7, 1946.
Tuition—$150.00 (veterans $90.00).
Registration fee $5.00.

OTOLARYNGOLOGY

Daily ward rounds, morning clinics and observation in surgery at Los Angeles County General Hospital and Children's Hospital. Afternoons devoted to lectures covering the field of Otolaryngology followed by instruction in dissection of the head and neck.

Duration—3 months (full time).
Students—maximum 8.
Courses begin Feb. 4, and Sept. 2, 1946.
Tuition—$250.00 (veterans $180.00.).
Registration fee $5.00.
(For item on Refresher Training see p. 90.)

Obstetrical and Gynecological Postgraduate Assembly of Southern California Announces Its First Annual Mid-Winter Clinical Assembly in Obstetrics and Gynecology

The Obstetrical and Gynecological Postgraduate Assembly of Southern California announces its first annual series of meetings for February 18-23, 1946, with the idea of bringing to this area authoritative scientific and clinical educational facilities from leading medical centers of the country. It is fully realized that additional medical meetings must be extraordinary in character if they are to attract representative men both as essayists and as auditors. The program as arranged meets adequately this prerequisite. Here on the West Coast we are so far removed from the Eastern areas that we are peculiarly in need of renewing, from time to time, our contacts with the educators of those sections. In order to benefit a larger number of our colleagues it has seemed far wiser to bring to us the leading men in our specialties rather than for us to attempt individual travel tours Eastward.

A precedent for this ambitious effort exists in the highly successful Research Study Club of Los Angeles, which has conducted postgraduate courses in Eye, Ear, Nose and Throat for the past fifteen years. We expect this new series to build a reputation for service of comparable stature.

Southern California, in spite of its geographical isolation, lends itself ideally to such a midwinter conference. Its population, medical and educational facilities, and oft vaunted winter climate all join in providing ample arguments for the success of the Assembly. The one difficulty that is anticipated is that the appeal will be so impelling that the initial limitation to one hundred will not admit all who wish to attend.

* * *

The Guest Speakers for the First Assembly will include: Dr. D. Emil Novak, Johns Hopkins Medical School, Baltimore, Maryland; Dr. Frederick H. Falls, University of Illinois, Chicago, Illinois; Dr. Paul A. Gliebe, University of California, San Francisco; Dr. Paul R. Patek, Ph.D., University of Southern California, Los Angeles; Dr. Roy W. Hammack, College of Medical Evangelists, Los Angeles; Dr. Madeleine Fallon, Hematologist, Los Angeles.

Dr. Emil Novak, Associate Professor of Gynecology at Johns Hopkins Medical School and Associate Professor of Obstetrics, Maryland University, and world authority on Gynecologic Endocrinology and Gynecologic Pathology, as well as Clinical Gynecology, will give ten lectures on these subjects. Anyone acquainted with Dr. Novak or his work well knows his great experience in these fields. A great scientist and untiring research worker, he has never lost sight of their practical application to Clinical Gynecology.

Dr. Frederick H. Falls, Professor of Obstetrics and Gynecology at the University of Illinois, will give ten lectures in Obstetrics. Among the subjects to be discussed are: Abortion, the Toxemias, the Conduct of Labor, and Cesarean Section. His wide clinical experience and alert teaching mind will contribute much to the success of the Assembly.

Dr. Paul A. Gliebe, Assistant Professor of Psychiatry, University of California, San Francisco, will lecture on the newer viewpoint of Psycho-somatic Medicine; first giving us the basic fundamentals and then their practical application in Gynecology and Obstetrics. This should be one of the highlights of the session, since this field of medicine has become so important the last few years.

Dr. Paul R. Patek, PH.D., Associate Professor of Anatomy at the University of Southern California, and Dr. Daniel C. Peace, Ph.D., and Dr. Barbara Granger, Ph.D., in the same department, will give lectures on the Anatomy of the Female Pelvis and Perineum; Recent Advances in our Knowledge of Conception, Implantation and Anatomy and Physiology of the Placenta; and the Cytomorphology of the Female Genital Tract with Reference to Endocrinology.

Dr. Madeleine Fallon, Hematologist of Los Angeles, and Dr. Roy W. Hammack, Clinical Pathologist, Los Angeles, will bring us up to date on the R. H. Factor. Both of these speak with authority on this subject, one of the newest, as well as one of the most confusing problems before us today.

The Round Table Luncheons each noon will be the heart of the Assembly. In general, the topics will be discussed along the line of the preceding lectures. In addition, all members of the Assembly are urged to enter into an informal discussion on any subject which deeply concerns them. Questions should be turned in, in writing, on subjects they wish discussed and the committee will then select someone well qualified to open the discussion. Lecturers should not be asked to discuss such questions with the individual. *Take them to the Round Table Luncheon so that all may benefit.*

Many of the members will wish to become acquainted with the guest speakers and with other members in an intimate personal way. For this purpose a "Bull Pen" has been provided. Parlor A-Lounge on the fourth floor of the Elks Club, where one may foregather with his fellows and relax over a cup of coffee or a glass of beer and indulge in an informal "Bull Session" at the end of each afternoon.

The Elks Club of Los Angeles, Sixth Street and Park View Avenue, will be the headquarters of the Assembly. All sessions of the Convention, as well as the Round Table Luncheons, will be held there. The Assembly will get off to a good start with a "get acquainted" social gathering at 3 p.m. Sunday, February 17, in the El Venado Room at the Elks Club. Be sure to be there. The regular meetings begin Monday, February 18, and continue daily with morning sessions from nine to twelve; the Round Table Luncheon twelve to two and afternoons from two to five, ending Saturday night with a formal banquet at the Ambassador Hotel. Wednesday and Saturday afternoons will be open for sightseeing, visiting movie studios or playing golf.

Despite the end of the war, transportation and hotel accommodations are still problems. It would be wise for those who plan to attend to make arrangements for accommodations *as soon as possible.* Should you prefer some hotel or apartment in Los Angeles, please write direct for reservations. Retain the reply from the hotel, in order that you may demand your rooms on arrival here. A certain number of accommodations are available at the Elks Club. If you wish to stay there write to Mr. H. M. Nickerson, Manager, Elks Club; 607 South Park View Avenue, Los Angeles 5, and he will secure suitable reservations for you.

The fee for the Assembly Course is $50.00. This includes all sessions of the convention and the banquet Saturday night at the Ambassador Hotel. (It does not include the noon day lunches). When you apply for the course use the inserted application blank and send $50.00 to Roy E. Fallas, M.D., 1930 Wilshire Blvd., Los Angeles 5, California. If anything prevents your attendance, this fee will be returned to you.

The number of members for the Assembly will be limited to one hundred. Members of the Los Angeles Obstetrical and Gynecological Society have priority, and will be given one week in which to register before the other invitations are sent out. Limiting the number to one hundred will give many advantages to those taking the course; but, it will of necessity limit the number of men from outlying sections that can be accommodated. The Assembly is to be an Annual Event and it is hoped that in subsequent years when more normal conditions return that it will be possible to invite more new members from more distant sections.

The Committee

U. C. Offers Dentists New Study Program

Establishment of a refresher course for practicing dentists and a self-supporting clinic in Los Angeles under the auspices of University of California Extension was announced on January 14 by President Robert Gordon Sproul.

Regents of the University have approved expansion of dental facilities located in the Los Angeles Medical Department of the University of California at 737 N. Broadway. Advanced and refresher courses for practicing dentists have been needed for some time, points out President Sproul.

The local facilities will be available to dentists both in southern and northern California. The program is established with the recommendations of Dr. Willard C. Fleming, Dean of the College of Dentistry on the San Francisco campus of the University and state dental associations. It is expected to facilitate extension of an educational program pioneered by the Southern California Dental Association.

A small, full-time administrative staff will be established while instructors in the refresher courses and practitioners in the clinic will be drawn from regular practicing members of the dental profession in this area.

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

National Conference on Medical Service

The 19th annual meeting was held on Sunday, February 10, 1946, in Palmer House, Chicago.

Program

9:00 a.m.—Registration, 4th floor, entrance of Red Lacquer Room.

9:30-9:50 a.m.—President's Address, *"Medicine and the National Crisis,"* C. L. Palmer, M.D., Pittsburgh.

9:50-10:20 a.m.—*"What Labor Expects from Medicine,"* Walter Reuther, Vice-President, United Auto Workers, C.I.O., Detroit.

10:20-10:50 a.m.—*"What the Farmer Expects from Medicine,"* J. S. Jones, Secretary, Minnesota Farm Bureau Federation, and Chairman, National Committee for Rural Health, St. Paul.

Discussion—Leonard W. Larson, M.D., Member of Committee on Rural Medical Care, American Medical Association, Bismarck, N. D.

10:50-11:20 a.m.—*"What Industry Expects from Medicine,"* Howard Strong, Secretary, Health Advisory Council, Chamber of Commerce of the United States, Washington, D. C.

11:20-12:00 noon—Open Discussion.

12:00-1:45 p.m.—Luncheon.

1:45-2:15 p.m.—*"Medical Care of Veterans,"* Major General Paul R. Hawley, Acting Surgeon General, Veterans' Administration, Washington, D. C.

2:15-2:30 p.m.—*"Aims and Purposes of Conference of Presidents and Other Officers of State Medical Societies,"* Andrew S. Brunk, M.D., President of "Conference of Presidents and Other Officers of State Medical Societies," Detroit.

2:30-2:45 p.m.—Questions and Answers.

2:45-3:00 p.m.—*"What About Returning Medical Officers?" "Postgraduate Opportunities,"* Victor S. Johnson, M.D., Secretary, Council on Medical Education and Hospitals, American Medical Association, Chicago.

3:00-3:15 p.m.—*"Establishment of State Bureaus of Information,"* Mrs. M. Virginia Shuler, Supervisor, Bureau of Information, American Medical Association, Chicago.

3:15-3:30 p.m.—*"Medical Legislation,"* J. W. Holloway, Jr., Director, Bureau of Legal Medicine and Legislation, American Medical Association, Chicago.

3:30-3:50 p.m.—*"National Plan for Volunteer Prepayment Medical Care,"* Jay C. Ketchum, Executive Vice-President, Michigan Medical Service, Detroit.

3:50 p.m.—Discussion.

Adjournment.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Pending Legislation Before Congress

The Second Session of the Seventy-ninth Congress opened on January 14, 1946. It is well to remember that the other Wagner-Murray-Dingell bills, namely S. 1050 and H. R. 3293 are on the dockets of the Senate Finance Committee and the House Ways and Means Committee. It is altogether possible that these committees may give the bills a hearing, especially since the House Ways and Means Committee is making a study of the Old Age Security law with the idea of suggesting revisions.

Names of members of Senate and House Committees follow:

Members of the Senate Finance Committee:

Walter F. George, Georgia, Chairman; David I. Walsh, Massachusetts; Alben W. Barkley, Kentucky; Tom Connally, Texas; Josiah W. Bailey, North Carolina; Harry Flood Byrd, Virginia; Peter G. Gerry, Rhode Island; Joseph F. Guffey, Pennsylvania; Edwin C. Johnson, Colorado; George L. Radcliffe, Maryland; Scott W. Lucas, Illinois; Brien McMahon, Connecticut; Robert M. La-Follette, Jr., Wisconsin; Arthur H. Vandenberg, Michigan; Robert A. Taft, Ohio; Leverett Saltonstall, Massachusetts; Hugh Butler, Nebraska; Eugene D. Millikin, Colorado; Owen Brewster, Maine; Harlan J. Bushfield, South Dakota; Albert W. Hawkes, New Jersey.

Members of the House Ways and Means Committee:

Robert L. Doughton, North Carolina, Chairman; Jere Cooper, Tennessee; John D. Dingell, Michigan; A. Willis Robertson, Virginia; Milton H. West, Texas; Wilbur D. Mills, Arkansas; Noble J. Gregory, Kentucky; A. Sidney Camp, Georgia; Walter A. Lynch, New York; Aime J. Forand, Rhode Island; Thas F. Wasielewski, Wisconsin; Paul H. Maloney, Louisiana; Herman P. Eberharter, Pennsylvania; Cecil R. King, California; Harold Knutson, Minnesota; Daniel A. Reed, New York; Roy A. Woodruff, Michigan; Thomas A. Jenkins, Ohio; Bertrand W. Gearhart, California; Frank Carlson, Kansas; Richard M. Simpson, Pennsylvania; Robert W. Kean, New Jersey; Charles L. Gifford, Massachusetts; Carl T. Curtis, Nebraska.

These two bills were analyzed in the *Journal of the American Medical Association* in the June 2, 1945, edition, but it might be well to emphasize a few of the important points brought out in that analysis:

(a) Provisions for grants and loans for hospitals and health center construction. Title corresponds closely with the provisions of the Hill-Burton Hospital Construction bill with significant exceptions. The Hill-Burton bill which is more acceptable, has passed the Senate and will very likely pass the House.

(b) Another section proposes grants to states for maternal and child health services, for services for crippled children and for child welfare. This is similar to S. 1318 which the House of Delegates disapproved by resolution.

(c) It also proposes grants to states for the development of more effective measures for the prevention, treatment and control of venereal diseases and tuberculosis.

(d) It would grant subsidies to states for use in providing medical care for needy individuals.

(e) But the section to which physicians should be particularly opposed is that which would set up a national social insurance system as a part of the Social Security system. Some of the objectional features are:

I. Bureaucracy:

It is appalling the bureaucratic control that would be necessary to administer a scheme of this type which would include, according to Senator Wagner's estimate, 135,000,000 people. It would require an army of inspectors, continually checking on the relationships of patients to physicians, to hospitals, to pharmacies; another army of auditors checking on the expenditures of funds; a smaller army of statisticians who would collect the data for the justification of the expenditures. If the experiences of European countries can teach us anything, many small bureaus and offices will be necessary throughout the country as centers for the local administration. All of these will be equipped with stenographers, clerks, bookkeepers, and will require rental and equipment appropriations. No small expenditure will be involved in the provision of printed forms which are so necessary in all government activities.

II. Free Choice:

It is said the bill offers the insured free choice of physicians. It must be remembered, however, that free choice can be exercised only among the physicians who are willing to accept government employment, and experience in other countries has shown us that where physicians are too popular, the government limits the number of patients permitted a physician; thus, obliging some to be content with a second or third choice. In the rural districts where medical care is limited and the government must provide, of course the residents will be obliged to be satisfied with whomever the government employs.

III. Eligibility:

To be eligible for medical benefits, the individual must have been currently insured for a period of at least a year and a half immediately preceding the time of making a claim, and must have earned not less than one hundred fifty dollars ($150.00) in the first twelve (12) months of that period. The bill provides, however, that the Surgeon General may determine for any calendar year or part thereof that every eligible individual "pay a fee with respect to the first service or with respect to each srevice in a period of sickness or course of treatment," and "shall fix the maximum size of such fee." He may also "limit the application of such fees to home calls, to office visits or to both, and may fix the maximum total amount of such fee payments" and further, "may also provide for differences in the maximum size of such fees or total amount of such fee payments for urban and rural areas" where differences occur between states or communities.

II. Cost:

S. 1050 and H. R. 3293 provide that every employed person shall contribute 4 per cent of his wages while the employer contributes another 4 per cent, and the self-insured shall contribute two and one-half per cent of his income while the state or community contributes another two and one-half per cent. The amounts of these contributions will, of course, vary with the prosperity of the country. The deficits, naturally, will have to be met with funds from general taxation.

Associated Press Poll of Congressmen

The Associated Press, as reported by Science writer Carey, conducted a poll of the Congressmen just before the Christmas vacation asking this question:

"Do you favor President Truman's proposal for a national prepaid 'health insurance' plan to be financed by additional social security taxes and by general government revenues?"

One hundred forty-one ballots were returned. Of these seventy-two voted "No"; forty-three voted "Yes"; seventeen were undecided; three were "non-committal" and six others gave qualified answers.

Of the seventy-five designated Republicans who returned ballots, only four expressed themselves in favor of the Truman proposal; nine were undecided; three were non-committal and one said that while he was against it at present, if modifications were made perhaps he would go along. Of the 63 designated Democrats, thirty-eight were for the proposal; twelve were opposed; eight were undecided and five gave qualified answers.—*Bulletin, Washington* Office, A.M.A. Council on Medical Service and Public Relations.

Proposed California Law on Unemployment Compensation Disability Benefits

Sacramento, Feb. 6.—Delay in acting upon the Shelley bill establishing a system of unemployment compensation disability benefits was protested today by Senator John F. Shelley, San Francisco, and C. J. Haggerty, secretary of the State A. F. of L.

The bill, which has Governor Warren's approval, has been passed in the Senate and is now in the Assembly Committee on Finance and Insurance.

Chairman Frank J. Waters ruled the bill will be taken up at the regular time for the committee meeting, which is not until next Monday. He said it might be impossible to give an opportunity for opponents of the bill to be here to make their arguments and declared legislators were occupied on other matters.

Delay Opposed

The bill would affect 2,600,000 persons now under the State compensation insurance fund and both Shelley and Haggerty insisted a delay until Monday is unreasonable.

The California Medical Association came out in the open today in opposition to the Shelley bill.

"The C.M.A.," said Ben Read, lobbyist for the organization, "is interested in the bill because it affects every doctor in the State. The C.M.A. is against the bill."

He said the organization was against enactment of the legislation "because we feel interim committees should complete their studies." Read referred to an Assembly and Senate Committee now engaged in study of compulsory health insurance and kindred issues.

"We feel," said Read, "that this is a portion of the general picture of health insurance and should await the reports of the interim committees."

Easy-Going Sesssion

Washington Connally, State Chamber of Commerce lobbyist, said he believed that to wait until Monday was "orderly procedure" since that is the time for the regular meeting of the committee.

The State Chamber, along with the major business and industry interests, are opposed to the bill.

The delay on the important disabilities benefit bill was held by many Legislators to be in line with the general easy-going manner in which the Assemblyman and Senators have approached legislation at the special session.

In the Senate Governmental Efficiency Committee, stalling tactics are still being employed in consideration of the Governor's $54,000,000 State public works bill.

The bill will be taken up again tomorrow. Several hundred items in the bill are yet to be examined by the Senators.—E. C. B., San Francisco *Chronicle*, February 7.

Concerning Free Literature on "Political Medicine":

(COPY)

NATIONAL PHYSICIANS COMMITTEE FOR THE
EXTENSION OF MEDICAL SERVICE

A Non-Political, Non-Profit Organization for Maintaining Ethical and Scientific Standards and Extending Medical Service to all the People

To the Editor.—This is not a request for financial support. It is an appeal for intelligent consideration of the literature referred to, and for your personal cooperation to meet this real emergency.

The people of America must be told that there is now a showdown fight on the issue of Political Medicine. The time has come when every physician must recognize that enactment of these bills will destroy the private practice of medicine in this country.

Under separate cover, by today's mail, we are sending you four important documents:

1. "Showdown on Political Medicine."
2. A second copy of "Political Medicine and Freedom of Enterprise."
3. Leaflet, "Political Medicine."
4. Leaflet, "German Doctors Under Nazism."

These documents should be carefully studied and passed on to friends or acquaintances. We will provide additional copies of the booklet, "Showdown on Political Medicine," and unlimited quantities of the leaflets for distribution by you. Simply order the quantities you can effectively use on the enclosed business-reply postcard.

If every doctor does his part, our system of private distribution of medical care can be preserved for the American people.

Sincerely,
NATIONAL PHYSICIANS COMMITTEE
FOR E.M.S.
(Signed) DR. EDWARD H. CARY,
Chairman.

P.S.—It's your move Doctor! Write your Senators and Congressmen today. Mail your request for literature now, stating number of copies you wish for distribution. No charge.

Address National Physicians Committee, Pittsfield Building, 55 E. Washington Street, Chicago 2, Illinois.

Surgeon General Parran's Letter Would "Muzzle" Health Staff

Dr. Thomas Parran's Communication On U. S. Health Program "Creates Amazement and Consternation" in Ranks

A letter sent by Surgeon General Thomas Parran of the U. S. Public Health Service to all officers of that governmental agency on the National Health Program has "created amazement and consternation" within the medical profession, according to an editorial in the January 12 issue of *The Journal of the American Medical Association.*

The mimeographed letter sent out by Surgeon General Parran, under date of December 10, follows:

Enclosed is a copy of House Document No. 380, which is the full text of President Truman's message to the

Congress on a national health program, a subject of the highest importance to every citizen. The message contains a comprehensive analysis of the health problems of the country and recommendations as to the pattern of legislation to deal with them.

It is a source of particular satisfaction to all of us who labor for the public health advancement that this should be the special subject of a Presidential message. For the first time we have the major elements of a national health policy officially stated in comprehensive terms. This has been a goal of all public health workers for many years, and the enunciation of such a policy by the Chief Executive gives the Public Health Service definite objectives for its future work.

On the same day as the message was delivered Senator Wagner introduced (for himself and Mr. Murray) S. 1606, and Representative Dingell introduced H. R. 4730, designed to implement the proposals of the President. In addition, several bills are pending in the Congress dealing with special phases of the President's legislative program. These include the hospital construction bills, the national mental health bills and the stream pollution bills, each of which would impose substantial additional responsibilities on the Public Health Service.

The appropriate executive agencies of the government have been specifically instructed by the President to assist in carrying out his legislative program as presented to the Congress on September 6. The President wrote to the administrator of the Federal Security Agency on October 4 requesting him "to take primary responsibility for legislative measures necessary to carry out the part of my message (Sept. 6, 1945) outlined in section 21 concerning a national health program to provide adequate medical care for all Americans and to protect them from financial loss and hardship resulting from illness and accident."

Every officer of the Public Health Service will wish to familiarize himself with the President's message and will be guided by its provisions when making any public statement likely to be interpreted as representing the official views of the Public Health Service.

THOMAS PARRAN, *Surgeon General.*

Commenting editorially on the letter, *The Journal* said:

"If the fourth and fifth paragraphs of this letter say what they seem to say, the President of the United States has instructed the executive agencies of the government to get behind his legislative program for the extension of health. The Surgeon General of the U. S. Public Health Service goes into action, ties the Wagner-Murray-Dingell bill right into the program and at least hints to his officers that they had better be careful about making any public statements with regard to the message.

"Many of those addressed in this instance are physicians in the private practice of medicine in the United States. They volunteered their services in the formation of hospital units to aid the people of this country in an emergency; they continued their membership in the Reserve of the Public Health Service after the war itself ended because it seemed to be desirable to have an emergency service available. If, however, men are to be directed in their thinking or muzzled in their speaking incident to their desire to be of service to the health of the nation, their rights as American citizens will have to prevail. Resreve officers will have to consider seriously whether or not they wish to maintain any official connection with such a Federal agency. Incidentally, it might have been better if General Parran had, in these final two paragraphs, said in shorter and clearer sentences exactly what he meant to convey."

On Admission of Osteopathic Physicians and Surgeons on Staff of Proposed Tulare District Hospital

The issue of whether or not osteopaths as well as medical doctors are to be admitted to a community hospital for Tulare came up at the county board of supervisors meeting as the board held a hearing on the election to form a Tulare hospital district.

As no actual objections to the formation of the hospital district were raised, the board fixed January 21 as the date of the election.

Dr. James Spencer, Tulare osteopathic physician and surgeon, appeared before the board to request that voters have a chance to decide whether or not the hospital which the district proposes to erect in Tulare if the election carries should be open only to medical doctors or to all physicians and surgeons licensed under Section 2, Chapter 5 of the State business and professional code, which includes doctors of osteopathy as well as medical doctors.

Leroy McCormick, legal advisor to the board, told him that the board had no power to call an election on any issue other than whether or not the district should be formed. He pointed out that whether or not the hospital was to be "open" or "closed" would depend on the decision of the board of five directors of the proposed district.—Dinuba *Sentinel*, December 27.

COMMITTEE ON MEDICAL ECONOMICS

American College of Radiology Approves New Type of Malpractice Coverage

The American College of Radiology, 20 North Wacker Drive, Chicago, 6, in its monthly *News Letter* of January, presents the following interesting information:

A special committee of the Board of Chancellors, after long negotiation, has effected a new comprehensive malpractice insurance policy for Members and Fellows of the American College of Radiology that offers distinct advantages over other such insurance now available to radiologists..

Besides offering a considerable saving in insurance costs to our members, the policy contains a broad insuring clause that is superior to that found in most malpractice policies. Without any malpractice exclusions, the company guarantees to pay "all loss by reason of the liability imposed by law upon the insured for damages on account of professional services rendered or which should have been rendered by him or any assistant to him."

For 25/75 thousand-dollar limits, this new policy will cost College Members and Fellows $65 a year on a three-year basis. The annual premium will be $79. O. L. & T. or public liability coverage is included. The premium for members in service is reduced one-half.

The presonal liability of assistants and technicians can be covered for 50 per cent additional for each named individual. Limits to 50/150 thousand dollars can be had by endorsement of the uniform policy and payment of added premium.

These rates are considerably lower than the premiums demanded for malpractice insurance covering x-ray diagnosis and therapy in all but two or three states at present. The total saving for all College Members and Fellows will amount to several hundred thousand dollars a year.

In recent years there has been increasing dissatisfaction with malpractice insurance for radiologists. A special committee of the American Roentgen Ray Society made an extensive study of the question ten years ago.

It's Still State Medicine

The President has asked for what the headlines call, "A law to force insuring of the nation's health." In the debate which is sure to ensue over this proposal, proponents and opponents will be listed categorically as either liberals or reactionaries—if you are for it you are liberal; if you are against parts of it, you are a reactionary. Tens of thousands of hard working doctors who are doing their utmost to carry forward America's high medical and health standards but who oppose certain parts of the President's program, will be termed reactionary.

And yet is it reactionary to point out that when the state compels every individual to contribute a part of his earnings toward support of a public undertaking, that undertaking must inevitably become the property of the state? When the Federal government forces a person to subscribe to a prepaid medical system sponsored by the government, is there any other name for it but "state medicine?" Likewise, is it reactionary to point out the obvious contradiction in the statement that patients will have a free choice of doctors, but doctors will not be compelled to join the program? Suppose the doctor you want is not a member of the state medical system? Indications are that many doctors will not permit themselves to be put on the government payroll unless forced to do so. In other words, in order to have your free choice you may have to pay your medical bill twice—once to the government for a doctor you don't want and again to the doctor of your actual choice.

These are some of the questions the "reactionaries" are concerned about.—Anaheim *Bulletin*, December 21.

Prepayment Medical Care Organizations Operating in California

The Social Security Board of the Federal Security Agency, through its Bureau of Research and Statistics has brought off the press Bureau Memorandum No. 55 on "Prepayment Medical Care Organizations." Copies of this report may be obtained from the Superintendent of Documents, Washington 25, D. C., but twenty-five cents must be enclosed for copy of the same.

In its 148 pages the brochure gives interesting data concerning prepayment organizations. Other interesting statistical tables and information are appended.

The California plans appear on pages 42 to 54. The prepayment medical care groups therein listed include the following:

1. C. and H. Employees' Mutual Benefit Association, California and Hawaiian Sugar Refining Corporation, Ltd., 215 Market Street, San Francisco, California. L. M. Van Deusen, Insurance Manager.
2. Southern Permanente Foundation, Kaiser Co., Inc., Fontana, California. Ralph D. Mills, Administrator.
3. Valley Health Foundation, Security Bank Building, Glendale, California. Syd Green, President.
4. Employees' Medical Fund, Metropolitan Water District of Southern California, 306 West Third Street, Los Angeles, California. J. M. Luney, Controller.
5. Pacific Electric Railway Company Hospital Association, Pacific Electric Building, Los Angeles, California. William L. Weber, M.D., Chief Surgeon.
6. Ross-Loos Medical Group, 947 West Eighth Street, Los Angeles, California. H. Clifford Loos, M.D.
7. Santa Fe Coast Lines Hospital Association, The Atchison, Topeka, and Santa Fe Railway Co. (Coast Lines), 610 South St. Louis Street, Los Angeles, California. W. A. Morrison, M.D., Chief Surgeon.
8. Union Oil Company of California Employees' Benefit Plan, Union Oil Building, Los Angeles, California. John L. Greer, Secretary.
9. Hospital Service of California, 360 Fourteenth Street, Oakland 12, California. J. Philo Nelson, General Manager. (Surgical Plan).
10. Permanente Foundation Health Plan, Kaiser Co., Inc., Oakland, California. Sidney R. Garfield, M.D., Medical Director.
11. Stowe-Lipsett Medical Group, 521 Fourteenth Street, Oakland, California. F. J. Wuepper, Executive Manager.
12. Intercoast Hospitalization Insurance Association, 1127 J Street, Sacramento, California. (Surgical Plan.) P. A. Stitt, General Manager.
13. Complete Service Bureau, 328 Maple Street, San Diego, California. Dave Parmer, President.
14. Agricultural Workers Health and Medical Association, 709 Mission Street, San Francisco, California. S. Kerby-Miller, General Manager.
15. California Physicians' Service, 153 Kearny Street, San Francisco, California. A. E. Larsen, M.D., Medical Director.
16. F. W. Callison, M.D., and Staff, 450 Sutter Street, San Francisco, California. F. W. Callison, M.D., Chief of Staff.
17. Frank M. Close, M.D., and Staff, 728 Twenty-second Street, San Francisco, California. Frank M. Close, M.D., Chief of Staff.
18. Franklin General Benevolent Society, Franklin Hospital, Fourteenth and Noe Streets, San Francisco, California. Frank Schmidt, Superintendent.
19. Health Service System of San Francisco, 305 Civic Auditorium, San Francisco, California. Alexander S. Keenan, M.D., Medical Director.
20. La Societe Francaise de Bienfaisance Mutuelle, Geary Street, between Fifth and Sixth Avenues, San Francisco, California. Charles J. Malinowski, Superintendent.
21. Hospital Department, Southern Pacific Co., Fell and Baker Streets, San Francisco, California. C. A. Walker, M.D., Chief Surgeon.
22. Hospital Fund, Tide Water Associated Oil Co., 79 New Montgomery Street, San Francisco, California. J. F. Peattie, Chief Surgeon.
23. Western Pacific Railroad Co., Western Pacific Building, San Francisco, California. Alson R. Kilgore, M.D., Chief Surgeon.
24. South San Francisco Hospital, 500 Grand Avenue, South San Francisco, California. Edwin I. Bartlett, M.D.
25. Aircraft Workers' Medical Plan, Douglas Aircraft Co., Inc., Main Office, 3015 Ocean Park Boulevard, Santa Monica, California. C. M. Hinchey, Manager.
26. Columbia Employees' Hospitalization Plan, Inc., Columbia Steel Co., Torrance, California. John H. Hanks, Secretary.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Orange County Medical Association Presents Series of Public Meetings

The Orange County Medical Association has announced a series of public meetings covering new development in the medical sciences as they affect public health. The meetings are booked for January 22nd, February 12th, March 12th and March 26th and will be held at the Little Theatre in the Santa Ana High School, 520 West Walnut Street, Santa Ana. List of topics follows:

PROGRAM

Jan. 22—*Penicillin—the Life Saving Miracle:*
    3 speakers. (Questions from the floor.)
Jan. 29—*Venereal Diseases:*
    3 speakers. 'Teen age not too young to learn. Everyone should be interested in the new approach to an old problem. (Questions from the floor.)
Feb. 12—*Preventive Medicine:*
    3 speakers covering Industrial Health, Postwar problems here and abroad, Tuberculosis, Cancer, and Heart Disease. (Questions from the floor.)
Feb. 26—*Modern Surgery:*
    3 speakers presenting the highlights of this intriguing subject. (Questions from the floor.)
Mar. 12—*Gifts of Modern Medicine:*
    3 speakers covering the evolution in diagnosis and treatment, the Medical Specialties, and the Female Hormones. (Questions from the floor.)
Mar. 26—*Blessed Events:*
    3 speakers bringing up to date knowledge under the following headings:
        What Price Baby?
        New Baby Health Insurance.
        Why a Cesarean Section?

Nutritional Aspects of Meat Shortage

Judging from the numerous calls received by the Los Angeles Health Department, the public is greatly concerned about the rumored meat shortage which might result from shutting down of meat packing establishments.

The "meat" of the situation is this: We are told that the independent packing companies can provide 60 to 70 per cent of the meat now being consumed. This supply will be ample if equitably distributed. Supplemented with protein foods other than meat, the reduced supply is no threat to optimum nutrition.

When food and money are plentiful, people eat more than is necessary to satisfy their needs for protein. A moderate reduction in available meat can therefore be sustained without nutritional loss. The problem to be met in satisfying appetites with less meat than usual is psychological and educational rather than biochemical.

To meet the 70 g. of protein per day recommended for an adult man weighing 70 Kg., the following foods may be consumed; 1 pint of milk, 3 ounces of meat, fish or poultry, 1 ounce of cheese or 1 egg,.3 ounces (1½ cup) of vegetables, 2 servings of fruit, 6 slices of bread. Some persons do not eat the well rounded diet outlined above. Others regularly eat meat twice a day, bringing their protein up to 90 g. or more, because they like meat. Vegetarians omit meat and add more milk, cheese, soybeans and grain products.

Those who feel abused at meat reduction need counsel on a psychological basis with the additions of information on ways to provide the "aminos" by proper combinations of available plant and non-meat animal proteins. It should be explained that certain protein foods if eaten alone are inadequate, but when teamed together, provide adequate essential proteins. People also need to be cautioned against the danger of buying uninspected meat, which will inevitably be offered if a meat shortage should be prolonged. Sources of protein other than meat: milk, cheese, eggs, beans, peas, fish, wheat bread, nuts, soybean, soybean bread, cereals, brewers yeast.

State Board of Public Health Items

90 Per Cent of V.D. Clinic Patients Have Syphilis

Approximately 90 per cent of patients treated in venereal disease public health clinics in California have syphilis. Patients with gonorrhea and other venereal diseases make up the other 10 per cent of the clinic load.

The total number of patients being treated in clinics which report to the Central Tabulating Unit of the State Department of Public Health dropped from 11,602 in July, 1944, to 10,627 in June, 1945. There was a slight increase in the number of patients with primary, secondary and early latent syphilis from 2,740 in July, 1944, to 2,962 in June, 1945.

* * *

Social Hygiene Day

February 6, 1946, has been designated National Social Hygiene Day. First designated in 1937, the day usually is observed in many California cities by civic meetings and other educational programs.

* * *

Registration of Sanitarians Heavy Under New Law

More than 600 applications for certification as a registered sanitarian have been received by the State Department of Public Health under the provisions of the 1945 Sanitarian's Registration Act, Chapter 5, Sections 540 to 542 of the Health and Safety Code.

Under the act, a sanitarian is defined as a "person trained in the field of sanitary science and technology who is qualified to carry out educational and inspectional duties and enforce the law in the field of sanitation."

The act requires that the State Department of Public Health shall certify as a registered sanitarian any person who qualifies himself by one of the procedures outlined in the law.

* * *

E. K. Middlehoff Retires

Mrs. Eleanor K. Middlehoff, supervising clerk for the State Department of Public Health, retired from State service at the close of 1945.

Through giving assistance of exceptionally high quality to 11 State Health Officers, Mrs. Middlehoff has played a leading rôle in the development of the public health program in California. Her willingness to share her rich experience has proved of invaluable help to many beginners who have since achieved recognition and she has among her friends a large number of persons who are nationally and internationally known in public health and related fields.

From the beginning of her service Mrs. Middlehoff has been closely associated with the State Board of Health in the preparation of agenda and information for consideration by the board and in the writing of the minutes. During her years of employment, few meetings of the board have been held without her being present and her powers of recollection have been particularly helpful in preserving a continuity of action through different administrations.

Always keenly interested and able in legislative and legal affairs, Mrs. Middlehoff recently has been engaged in codifying for publication the rules and regulations of the State Board of Health.

The Doctor's Advice Is Best on Caring for a Baby, Says C. of C. Health Committee

From the time of its birth, every baby should have the benefit of care under the supervision of a doctor. Such is the advice of Health Advisory Council of the Chamber of Commerce of the United States, Washington.

"As pointed out by the Children's Bureau, most babies are well when they are born, and one of the most important helps toward keeping a baby well is the advice of a good doctor, particularly during the baby's first year when growth and development are fastest."

To keep a baby well, the Children's Bureau advises parents to:

See that he has a complete physical examination as soon after birth as possible and another about 2 to 4 weeks later.

Take him to a doctor regularly for general supervision.

Supply him with clothes that keep him comfortable and give him freedom to grow and use his developing powers.

Encourage him to grow up, but never try to force him ahead faster than he wishes to go.

Play with him.

Help him develop good habits.

See that he gets plenty of undisturbed sleep.

Keep him clean.

Give him as much sunshine and fresh air as the weather permits.

Give him enough clean, good food, at regular times and remember that breast feeding is best for the baby.

Keep him away from all sick people.

Make sure that he is given inoculations to protect him against diphtheria and smallpox, and also against whooping cough and tetanus if the doctor so advises.

Give him plenty of love and affection.

Try to give him a peaceful, happy babyhood in a peaceful happy family. Mothers who cannot afford to pay a private physician should consult their local or state health departments for the addresses of clinics or child-health conferences, the health committee suggests.

Influenza Decreasing—Type B Influenza Present in Los Angeles

According to the number of cases reported through January 12, to the Los Angeles City Health Department, influenza seems to have reached its peak and the trend is now down. There were 9, 17, 16, 82, 74, 128, and

190 cases reported respectively for the last seven weeks previous to this week and 1, 0, 0, 2, 5, 6 deaths. In the week of January 6, there were only 85 cases and 7 deaths.

While the number of cases reported comprise but a small fraction of the real total, it does give an index of trends. Only a small percentage of patients have a physician in attendance; and in many of these, reports are not made to the health department because of uncertainty of diagnosis on the part of the physician and other reasons.

Dr. Harold Pearson, virologist at the Los Angeles County Hospital, has found serologic evidence of the presence of influenza virus B in Los Angeles. Whether or not influenza A is here also has not been determined.

Vaccine for influenza virus A and B is commercially available now and seems to have some protective value. It must still be considered to be in the experimental stage, however and is quite expensive, costing around $2.20 for the material for one immunization. It is apparently safe to use; it reduces the total number of cases of influenza in any given group, but does not develop immunity in every person so treated. Evidence indicates that immunity to the influenza virus is of short duration, probably only a few months. Economy would dictate, therefore, that influenza virus vaccines be given only in the face of a known epidemic rather than in anticipation of an outbreak.

Traffic Deaths and Personal Injuries

Because of the appalling increase in traffic deaths and personal injuries since V-J Day, August 14, 1945, and, because this increase is becoming nothing less than slaughter on the highways, the Medical Staff of the San Antonio Community Hospital, of Upland, California, met in conference on the evening of January 15, 1946, at the San Antonio Community Hospital, along with the law enforcement officials of the West End of San Bernardino County, the morticians and ambulance owners, the judges of the various courts and representatives of the Press, for the purpose of discussing and making recommendations of ways and means to reduce materially the heavy and unnecessary traffic fatalities. After a full evening of discussion by all those representatives present, a committee of three was appointed, consisting of Captain Frank Freeman, California Highway Patrol, San Bernardino County, Eugene Meuller, Chief of Police, Upland, California, and A. A. Aita, Superintendent of the San Antonio Community Hospital, Upland, California, to draw up a resolution incorporating the main factors brought out by this discussion.

Copy of resolution follows:

Resolution Adopted by the Safety Meeting of the Medical Staff of the San Antonio Community Hospital, Law Enforcement Officials, Township and Community Officials and Representatives of the Press, on January 15, 1946, at Upland, California

WHEREAS, The traffic accidents and the deaths resulting therefrom, have become a little less than slaughter since V-J Day; and

WHEREAS, These highway accidents are increasing monthly rather than decreasing; and

WHEREAS, Because a wanton disregard for safety on our highways is becoming more and more prevalent and a continuance of such disregard for safety will maim and kill hundreds of thousands of our population; now, therefore, be it

Resolved, That the following be provided without delay:

1. More traffic officers and greater frequency of patrol.
2. Driver educational program and
   a. Educational program in our Junior and Senior high schools, with "behind the wheel" actual instruction.
   b. Prerequisite training and certification before issuance of driver's license.
   c. Physician's approval of ability of driver with physical disability.
3. All drivers involved in accidents to be reëxamined within thirty days or driver's license revoked.
   a. Immediate revocation of licenses of all drivers involved in accidents resulting in personal injury or death, pending reëxamination.
   b. Drivers apprehended operating a motor vehicle without a license to be incarcerated in county jail for a term of not less than ninety days, and during such incarceration, at the discretion of the department of motor vehicles, perform such duties in the general program to enhance the safety of our highways.
4. Heavier and uniform fines and sentences along with impounding of cars on all violations of drunken driving and/or reckless driving and/or driving without due caution or any wanton disregard of safety on the highway.
5. Improved engineering on all main highways to be at least four lane divided highways.
   a. Immediate survey of dangerous intersections and removal of all obstructions impairing visibility.
   b. More frequent location checks on mechanical equipment and driving ability by all traffic officers.
   c. Adequate flood lighting of intersections, particularly those used by pedestrians and all main intresections.

Taxes Don't Insure Health

In his message to the legislature, Governor Earl Warren proposes a number of public health measures. Examples are the proposed School of Medicine for the University of California at Los Angeles, expansion of hospitals for the mentally ill and establishment of more hygiene clinics.

He did not mention compulsory prepaid health insurance, a measure which he sponsored at the last session.

In Washington, a poll of part of the Congress indicated a 7 to 4 margin of opposition to President Truman's compulsory insurance plan.

Opposition to the California and national health programs is based upon the argument that they do not insure health, that they are, in fact, taxation programs and very heavy ones.

In insurance, the rate or premium is proportionate to the risk involved. Policyholders who offer the same risk pay the same rate.

In the so-called health insurance programs, the man with good health gets no rating advantage over the man with ill health. Payments are not based upon the probable cost of caring for the individual, but upon his income.

Under President Truman's plan a man earning $300 a month would be taxed $144 a year. Another man earning $100 a month would be taxed $48 a year. They would receive the same protection. It may be a good idea, but it's not insurance.

The taxes which support our public hospitals and clinics are based upon the ability to pay taxes. The prosperous people help to provide facilities for their less prosperous, less healthy and less capable fellow citizens. It is a humane and reasonable public service. President Truman's plan might extend it.

But it's a misnomer to call it insurance and it should not be presented as such.—Hollywood *Citizen News*, January 15.

Organization of Medical Research Fund Completed

The organization of the Life Insurance Medical Research Fund has been completed and allocations of money will be begun shortly for research into diseases of the heart and arteries, announced M. Albert Linton, chairman of the joint fund committee of the American Life Convention and the Life Insurance Association of America. Mr. Linton disclosed that more than 143 life companies in the United States and Canada have been enrolled as members, while funds of more than $3,500,000 are in prospect over the next six years.

"Research into the diseases of the heart and arteries has been chosen as the first field for attention by the fund because of its primary importance to the public and to life insurance policyholders. These diseases are the primary cause of death in the United States. Records show that they are responsible for nearly one-third of all policy-holder deaths," said Linton.

He explained that funds also will be allocated to support men in the research field who would be unable to carry on their activities unless aided in this way. These men will be called Life Insurance Medical Research Fellows.

A committee of four life insurance medical directors has been appointed to acquaint the Fund's advisory council with problems pertinent to life insurance, and to keep their own organizations informed about the work of the Fund, said Linton. A recognized leader in the field of medical research is being sought for the post of scientific director, he said, and as soon as the selection is made headquarters will be established and consideration of grants of funds will begin. Asa V. Call, president of Pacific Mutual Life, is a member of the board of directors of the Fund.

How Health Was Guarded In Atom Work

Elaborate precautions, including medical research as a scientific guide to the most effective use of safety devices, resulted in perfect protection against radiation for workers on the atomic bomb project, the University of Rochester said today.

A report on medical research conducted at the university under contract with the Manhattan Engineer District, in charge of atomic bomb development, declared that not a single person was injured by radiation while working on the project.

The report was approved by the office of Major General Leslie R. Groves, who directed the district.

A spokesman for the medical research project, organized here in March, 1943, said the work "may well have far-reaching effects in several branches of medicine, notably in the field of metabolism, both normal and pathological, and especially in cancer research."

The report also stated that physiological investigations of the mechanism of intoxication observed after radiation exposure "may have an important bearing upon the treatment of shock encountered in ordinary medical practice."

The laboratory, which devised safeguards for workers and new electronics instruments to measure the amount of radiation exposure, was in daily contact with atomic bomb assembly and research plants throughout the United States.

Animals Exposed

Samples of human workers' breath were taken and analyzed for evidences of radiation. In addition, workers wore pieces of unexposed film, protected against light. If the film was clouded upon development it indicated some radiation had reached the wearers.

"This information helped plant managers in determining when and where employees needed to wear rubber gloves and other protective devices against radiation," the report stated.

The amount of acute radiation that could be tolerated by a population in the event of accident or enemy action was studied in experiments during which animals were subjected to large single doses of radiation.

Council on Medical Service and Public Relations: American Medical Association

Its Immediate Labors

1946 Year for Action

1945 was American medicine's year of decision.

1946 is American medicine's year for action. In 1945 the Fourteen Point Constructive Program for Medical Care was proposed by the A.M.A. Council on Medical Service and Public Relations, approved by the Board of Trustees, and sanctioned by the House of Delegates.

Now 1946 must see this program put into action. That will be one of the chores of the Council. Two other tasks placed specifically on the Council by the House of Delegates are:

1. Organization and incorporation immediately of a National Health Congress representative of the medical, dental, hospital, nursing, pharmaceutical, and allied professions.

2. Development of a specific national health program, with emphasis on the nationwide organization of locally administered prepayment medical plans sponsored by medical societies.

Local Voluntary Plans Should Be Stepped Up:

Development of local and state voluntary prepayment plans should be stepped up a pace rather than slowed down as a result of the action of the A.M.A. House of Delegates providing for the establishment of a national health insurance program. Word has come that work on several local plans has come to a momentary halt in anticipation of the national program as local groups apparently want to take a look-see at the A.M.A. proposals before going ahead with their program. This perhaps is only natural and logical but if continued it would tend to defeat the purpose of the action taken by the House of Delegates.

A Difficult Task:

As previously pointed out development of a national over-all plan is difficult and some even believe a "well-nigh" impossible task. No matter how difficult the tsak, it is the definite, determined desire of the Council to present such a plan to the Board of Trustees, but it will take time for a specific program to be formulated. Hence, work on plans now being done by state and local societies should go forward. This is not a static problem but one as chuck full of variables as an Einstein equation. The more varied these local plans are in form, the better this may be in the long run for the most workable, overall master plan will come finally only through trial and error and evolution. This is the true scientific process. In fact here are the steps to be taken before a national program can be submitted to the public:

1. Formation of a plan by the Advisory Committee on Prepayment Medical Care of the Council.

(This is being done by the Committee and it expects to be ready to make a preliminary report this month.)

2. Presentation of program for approval of the Council itself.

3. Presentation to Board of Trustees for approval.

4. Notification of the Societies of the plan.

5. Release of the plan to the public.

To complete each one of these steps even if all goes as smoothly as is hoped will take some weeks.

How Socialized Medicine Has Operated in New Zealand

Some striking facts showing the effects of a system of state medical care in actual operation are reported by Quentin Pope, a journalist, who has been making a study of the system in New Zealand. That country, under a socialist government, adopted a program of state medical care six years ago. It has resulted in greatly increased costs, overcrowded hospitals, a demoralized medical profession, and a general lowering of the standards of medical care.

The number of civilian persons admitted to hospitals in New Zealand has more than doubled, although the population has increased very little. In each hospital, much of the capacity is taken up by aged and chronically ill patients who ordinarily would have received care at home, but have been dispatched to hospitals by families eager to be relieved of their care. As a result, many vital hospital services have suffered. At the same time, the national bill has quintupled, from an original 5,000,000 a year budgeted for all physicians' services, to a present budget of $25,000,000 per year.

The number of consultations has greatly multiplied, in spite of a wartime shortage of doctors, and a large number of the patients are described as persons anxious to "nurse their neuroses." As a result, overburdened physicians often deny care to cases presenting complications and dispatch them to hospital in order to run their practice on a production-line basis. Nearly all members of the profession agree that it has lowered standards of medical care and encouraged doctors to think primarily of getting the maximum number of fees.

We believe these evil results are inseparable from any system of compulsory medical care fostered by the government. A far better solution of the problem of bringing medical and hospital care within reach of the average wage earner is offered by voluntary nonprofit health care programs such as the Blue Cross. Medical societies all over the country have endorsed these plans and advocated their extension. If the medical profession will get behind them, there is no question but that they can be made far more effective and beneficent than any plan of socialized medicine. They might enlist the services of the best men in the profession, as socialized medicine seldom does.—Mountain View *Register-Leader*, December 20.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

General Eisenhower Commends Army Nurse Corps on Their 45th Anniversary

In commemoration of the forty-fifth anniversary of the Army Nurse Corps, General Dwight D. Eisenhower, Chief of Staff, has issued the following statement:

"In joining the celebration of the forty-fifth anniversary of the Army Nurse Corps, we of the Army are glad to say that it has been our privilege to serve with these fine soldiers. During World War II the members of the Army Nurse Corps have served with the Army wherever it has been stationed. They have shown us that for them no day has been too long nor night too dark.

"We know that the demands we have placed upon them in hospitals both at home and overseas have called for unusual courage and great sacrifice. We also know that with inherent fortitude they have met, with our fighting men and the wounded, conditions to strain the nerves of the staunchest. And today, we find them still keeping faith with our convalescent troops wherever they may be.

"On February 2, 1946, when the Army Nurse Corps celebrates its founding, thousands of men will recall with grateful appreciation the many occasions when understanding Army nurses have helped them through dark moments. For the loyal women the Army Nurse Corps has given us since its inception and for its supporting rôle in the recent world conflict, I add my sincere and humble thanks. I know all Americans will join me in saying 'Many happy returns of the day.'"

Facts About Nursing 1945

Facts About Nursing, 1945, statistical handbook published by the Nursing Information Bureau, presents evidence of the scope and volume of the contribution of the nursing profession to the war effort.

More than 100,000 registered professional nurses volunteered for military service, and well over 75,000, approximately one-third of the total number known to be in active practice of their profession, have given service to the sick and wounded of the Army and Navy. Over $175,000,000 appropriated by Congress for nursing education since 1941, resulted in spectacular increases in enrollment of students in schools of nursing, and in the number of nurses graduated each successive year. A growing proportion of nurses over 50 years of age who cared for the sick at home and in hospitals, is further evidence of the patriotic response of older, retired and married nurses to the nation's need.

The need for more nurses qualified through advanced preparation and experience to render responsible and specialized services, is indicated in reports of vacancies on nursing school faculties; of almost 1,000 counties which have no public health nursing services; and of disturbing increases in the incidence of such diseases as diphtheria, poliomyelitis and tuberculosis. Opportunities are set forth in the chart which forms the center spread of the pamphlet. Minimum and maximum salaries depending on the preparation and responsibilities involved, head each column.

The 1945 edition of *Facts About Nursing,* like its several preceding issues, may be ordered from the Nursing Information Bureau of the American Nurses' Association, 1790 Broadway, New York 19, N. Y. The price is 25c.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

UNRRA to Outfit 28 Hospitals in Europe

Packaged as neatly as deliveries from a city department store, complete outfits for 28 hospitals, totaling more than 26,000 beds, are on the way to three stricken countries in Europe as result of efforts of special representatives of the United Nations Relief and Rehabilitation Administration, according to word received at the agency's Washington headquarters.

The hospital outfits, purchased from Army surpluses in the United Kingdom and on the European continent, are being trucked or shipped by sea to Poland, Czechoslovakia, and Yugoslavia. After VE-Day, the Army intended to trans-ship the outfits to Japan, but victory in the Pacific made that unnecessary.

Hence, thousands of sick men, women and children in the three countries will have available in a short time hospital facilities which otherwise probably would not have been open to them for years.

The outfits are so complete that they include everything from surgical instruments to beds and blankets, account books and case record charts.

Diseases resulting from malnutrition, exposure and filth have swept across Poland, Czechoslovakia and Yugoslavia. Tuberculosis and venereal infections have shown vast increases. . . .

UNRRA will not supply buildings for the hospitals. The individual governments will furnish them, and the outfits furnished by UNRRA will transform them into operating institutions.

Tuberculosis Patients in General Hospitals

Many general hospitals refuse admission to patients afflicted with pulmonary tuberculosis and many insist upon the removal of patients whenever diagnostic study discloses the presence of this disease. Advances made in the treatment of tuberculosis, particularly "collapse therapy" and other surgical procedures, make it readily possible for the general hospital to admit many such patients, particularly in certain phases of the illness, but special institutions and tuberculosis sanatoria will still be needed. General hospitals could materially assist in the campaign for the further reduction and possibly the eradication of pulmonary tuberculosis by providing routine radiological examinations of the chests of all patients upon admission. New techniques have materially reduced the costs of such examinations. As a routine procedure, chest filming has been shown to be of greater value in disclosing abnormal conditions than is true of many other routine diagnostic procedures now generally practiced, such as urinalysis, blood counts and serological examinations. *Hospital Survey News Letter,* Commission on Hosp. Care, Nov., 1945.

MEDICAL EPONYM

Waterhouse-Friderichsen Syndrome

Rupert Waterhouse (b. 1873), pathologist and assistant physician at the Royal United Hospital, Bath, reported "A Case of Suprarenal Apoplexy" in the *Lancet* (**1**:557, 1911). A portion of the article follows:

"A male child, aged 8 months . . . throughout the morning had been very drowsy and had 'looked strange' . . . had not seemed in pain, had taken nourishment readily, and . . . the bowels had acted as usual. About 3 o'clock in the afternoon he vomited. . . . Previously the child had always seemed perfectly healthy. . . . On account of the parents' conscientious objections the child had never been vaccinated. . . .

"On admission the infant was obviously very ill: complexion grey, eyes dull, breathing rapid, shallow, and noiseless; temperature 100.4°F., pulse 140, and respirations 72. Rales could be heard all over the chest. . . . There were no signs of meningitis, and nothing abnormal was to be seen in the mouth or fauces. Two hours after admission an extensive eruption of purple spots and blotches appeared over the whole trunk, upper arms and thighs. . . . The child rapidly grew worse, . . . and death occurred at 7:30 p.m.

". . .The post-mortem examination was made 22 hours later . . .

"The lungs were congested and œdematous. . . . The supharenal capsules were striking objects even before their removal from the body; of little more than normal size for a child of his age, they were both of a deep purple colour and evidently the seat of hæmorrhage. . . . Microscopically the structure of the medulla was seen to be completely destroyed and replaced by effused blood. . . . All the other organs appeared natural. . . .

"The case related above appears to form one of a distinct group . . . all infants between the ages of 2 and 15 months, and all of whom died after an illness lasting in the majority less than 24, and in none more than about 48 hours. In all but three a hæmorrhagic rash of greater or less extent was present. . . . Apart from the lesions of the adrenals and the hæmorrhagic rash, the most constant post-mortem findings have been intense engorgement of the lungs. . . . "

Eight years later Carl Friderichsen (b. 1886), then assistant in the children's department of the State Hospital in Copenhagen, discussed "Nebennierenapoplexie bei kleinen Kindern [Suprarenal Apoplexy in Young Children]" in the *Jahrbuch für Kinderheilkunde und psysische Erziehung* (**87** N. F.: 109-125, 1918). A portion of the translation follows:

"Although suprarenal hemorrhages in the newborn . . . are not an unusual finding, they must be regarded as rare occurrences in older infants, and the lesion is then as a rule bilateral, symmetrical and takes place so acutely that we occasionally are confronted with a sudden fatal result. . . .

"The disease seems to occur with equal frequency in boys and girls. The greater number of the patients are originally breast-fed infants who have later been placed on mixed diets. . . .

"The affected children have uniformly been quite healthy, well developed and nourished, who have never had anything the matter with them, and who during the preceding day and evening complained of no symptoms of any sort. Toward morning they awoke suddenly with a cry, often vomited, and occasionally had thin, scanty evacuations. Rarely convulsions are described. The illness quickly assumes disturbing characteristics. The patients are brought to the hospital almost moribund, with marked and constant *alternating cyanosis and pallor,* but without severe dyspnea and without signs of pulmonary disorder—a temperature of 39 to 41°C. [102.2 to 105.8°F.] a small, soft, very irregular pulse, with some unconscious and others visibly disturbed by marked anxiety. Examination reveals normal heart and lungs. As a rule several hours after the onset of the illness, often only a few hours before exitus, there appears scattered over the trunk, the extremities and the nates, in addition to the marked cyanosis, a *purpuric eruption,* at first in the form of small reddish-blue petechiæ with angulated or star-shaped outlines, quickly developing into suffusions the size of the palm, rounded in shape, the edges merging and finally becoming confluent with an elevated blue-black surface. Death follows shortly from six to twenty-four hours after the first indication of the disease, without one's being able to find other symptoms or any specific cause.

"Autopsy regularly shows only the skin hemorrhages and hemorrhages in the suprarenal glands, both in the cortex and the medullary zone."—R. W. B. in *The New England Journal of Medicine.*

Tuberculosis Mortality Rates

There is still much ahead in the control of tuberculosis. Mortality reports may give the number who die, but it is also necessary that contacts be ascertained to find others who need medical care or to locate sources of infection who must be kept apart from the well. In 1943, only 33 per cent of the deaths from tuberculosis in Indiana were reported before the death certificate was recorded. Many of these were undoubtedly properly diagnosed and under care for some time, yet there were also many whose disease was not recognized until too late.

There is need for greater recognition of the problem of the recovery of the aged. Many are of the chronic type, able to be about, and therefore more dangerous because of the potentialities of spreading infection to others, particularly young chldren. Tuberculosis mortality rates are falling, but in general the percentage reduction is much higher in the younger groups than among those of older age. Murray A. Auerbach, Bulletin, Indiana State Bd. of Health, Nov. 1945.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Headquarters, Hotel Biltmore, 5th and Olive Sts. Dates of meetings: Tuesday, May 7-Friday, May 10, 1946.

American Medical Association. The next annual session of the American Medical Association will be held in San Francisco, July 1-5, 1946. (Monday-Friday, inclusive.)

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in CALIFORNIA AND WESTERN MEDICINE for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576. Also, August, 1945, CALIFORNIA AND WESTERN MEDICINE, pp. 61-62.) On p. 61 (C.M.A.) and p. 62 (A.M.A.)

Medical Broadcasts*

The Los Angeles County Medical Association:

In February KFAC will present broadcasts on Saturdays at 10:15 a.m.; February 2, 9, 16, and 23.

The Saturday broadcasts of KFI are given at 9:45 a.m., under this title, "The Road to Health."

"Doctors at War":

For radio broadcasts of "Doctors at War" by the American Medical Association, see *J.A.M.A.*

Pharmacological Items of Potential Interest to Clinicians*:

1. *Journals of the Year:* American Geriatrics Society announces *Geriatrics*, published by *Modern Medicine*, Minneapolis. So C. C. Thomas, Springfield, Ill., offers *Journal of Gerontology*, edited by R. A. Moore, at $6 yearly, with $3 for annual non-technical supplement. B. Schwabe, Basel, Switzerland, announces that *Helvetica Medica Acta* will forthwith be joined by new *Helvetica Chirurgica Acta* and *Helvetica Paediatrica Acta*, 6 issues yearly at 42 Sw. Fr. each. Academic Press, N. Y., offers *Journal of Colloid Science*, edited by V. K. LaMer, at $10. Schuman's, 20 E. 70th, N. Y. 21, sponsors *Journal of the History of Medicine and Allied Sciences*, at $7.50, edited by G. Rosen, with interesting articles by C. Singer, J. C. Trent, G. Urdang, J. B. de C. M. Saunders, P. I. Nixon & Co. S. R. Detwiler gives well deserved tribute to grand old editorial board of *The Journal of Experimental Zoology* (*Science*, 102:610, Dec. 14, 1945). English physiologists offer helpful suggestions to authors (Ed. Bd., *J. Physiol.*, 104:221, 1945).

2. *Reviews and Symposia:* Note G. W. Beadle's keen survey of biochemical genetics, including data on cancer (*Chem. Rev.*, 37:15, 1945). W. B. Cannon and R. M. Field well review international relations in science (*Chron. Bot.*, 9:253, 1945). A. F. Barena summarizes data on ocular onchocerciasis (*Arch. Aso. evit. Ceg. Mexico*, 3:49, 1945). B. A. McSwiney's Penser Lecture covers visceral sensation (*Irish J. Med. Sci.*, 6th ser., No. 239, Nov., 1945). J. N. Davidson's fine Gillespie Lecture is on nucleoproteins in growth and development (*Edin. Med. J.*, 52:344, 1945). Sir Howard Florey's Lister Lecture on use of microörganisms for therapeutic purposes appears (*Brit. Med. J.*, 2:635, Nov. 10, 1945). A. Ritter reviews use of catgut sutures (*Helv. Med. Acta, Suppl.* 15, 1945). English authorities give comprehensive symposium on dermatology (*Brit. Med. Bull.*, 3:158-197, 1945). Forty-two friends of I. Chavez offer valuable contributions on cardiology in honor of his 25 professional years (*Libro Homenaje al Prof. Dr. Ignacio Chavez*, Nat. Univ., Mexico, 1945). W. B. Bean reviews cutaneous vascular "spider" (*Med.*, 24:243, 1945).

3. *Histamine:* W. J. Kerr & Co. report histamine-like material in nasal secretions of "common cold" and allergic rhinitis (*Am. J. Physiol.*, 144:706, 1945). Mayo Clinic staff note value of new anti-histamine compound, p-dimethylamino-ethyl benzhydryl ether HCl. Parke-Davis (*Proc. Staff Meetings, Mayo Clinic*, 20:417, Nov. 14, 1945). This is confirmed by our W. A. Selle, who has mss. on histamine with over 400 references.

4. *BAL:* British Anti-Lewisite, effective heavy metal detoxicant, is finally revealed by R. A. Peters, L. L. Waters and C. Stock as 2,3-dithiopropanol (*Science*, 102:601, Dec. 14, 1945; *Nature*, Nov. 24, 1945). Acting by competing with proteins for arsenic it prevents inhibition of enzyme systems by heavy metals and reactivates such poisoned enzymes. Although irritating and toxic it is clinically useful in heavy metal poisoning. How about cyanide?

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† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week. In CALIFORNIA AND WESTERN MEDICINE, some rosters appear in every second or third issue.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacological Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

5. *Toward a Better New Year:* Univ. of California Press offers *United Nations Charter and Accompanying Documents* (2 vols., $17.50). Commonwealth Fund publishes studies of N. Y. Academy of Medicine Committee on Medicine and the Changing Order; E. J. Stieglitz's *A Future for Preventive Medicine* is out (Commonwealth, 41 E. 57th, N. Y. 22, 95 pp., $1). Princeton Press announces History of Ideas Series, of which B. N. Nelson's *Idea of Usury* and M. H. Nicolson's *Newton Demands the Muse* sound promising (resp.: 150 and 175 pp., $2 and $2.50).

6. *ETC.:* S. Mazza & Co. report studies on Chagas disease (*Pub. 69, Univ. Buenos Aires, Mis. Est. Patol. Reg. Argentina,* 1945). E. Singer further emphasizes intracellular oxidases in detoxication of bacterial toxins (*Austral. J. Exp. Biol. Med. Sci.,* 23:165, 171, 1945). J. Gillman & Co. find phryoderma not due to vitamin A deficiency (*S. Afr. J. Med. Sci.,* 10:67, 1945). P. Yazigi & Co. discuss failure of anatomical repair in cirrhosis of liver (*Rev. Med. Chile,* 73:755, 1945). E. W. Page reports on dopa decarboxylase activity of human tissues (*Arch. Biochem.,* 8:145, 1945). R. C. Herrin and W. J. Meek demonstrate vomiting from afferent stimulation by intestinal distention (*Am. J. Physiol.,* 144:720, 1945). G. L. Engel & Co. continue quantitative E.E.G. studies, comparing anoxia, acute alcoholism and hypoglycemia (*J. Clin. Invest.,* 24:691, 1945). Our E. H. Frieden and C. N. Frazier find blood plasma enhances penicillin action (*J. Bact.,* 50:279, 1945). Our C. M. Pomerat notes inhibition of reticuloendothelial immune serum on growth of Walker rat sarcoma in vitro (*Cancer Res.,* 5:724, 1945). Our H. J. Ralston and A. N. Taylor observe streamline blood flow in arteries and indicate its importance in work of heart (*Am. J. Physiol.,* 144:706, 1945).

Stanford Medical School Receives Paralysis Grant.—Stanford University School of Medicine has received a grant of $17,310 from the National Foundation for Infantile Paralysis, it was announced on January 20 by Dr. Donald B. Tresidder, president of the university, and Basil O'Connor, foundation president.

The grant, to be used for infantile paralysis research, supplements $60,490 previously given to the school for the same purpose.

Funds for all such grants come from contributions to the March of Dimes.

Dr. Karl F. Meyer, director of the Hooper Foundation at the University of California Hospital, urged citizens to back that March of Dimes appeal and its scientific research program.

Half the money to be raised in the current campaign will go to the National Foundation for Infantile Paralysis and the remainder will be used to provide care for local victims of polio during the coming year.

Dr. Meyer pointed to San Francisco as an area of unexpected polio status. During 1944, the incidence of infantile paralysis was normal, but last year there were 82 cases.

While polio has not yet been controlled, gains have been made in reducing paralysis and the mortality rate, Dr. Meyer said. Fifty per cent of patients have completely recovered and the mortality rate has dropped to less than nine per cent.

Encephalitis Work Revealed at U.C.—Isolation for the first time in California of the St. Louis type encephalitis virus and proof that the common mosquito is the most important carrier of horse type encephalitis infection in San Joaquin Valley have been reported by the Hooper Foundation for Medical Research on the San Francisco campus of the University of California.

Presence of the St. Louis type virus in California was suspected, but had not been proved. The virus was isolated from a common mosquito caught in Kern County.

The Hooper researchers, Dr. W. McD. Hammon and Dr. W. C. Reeves, have also verified that the outstanding sources of horse and St. Louis encephalitis viruses for mosquitos are fowl, both domestic and wild.

The conclusions are the result of a study of an epidemic in 1943 of horse encephalitis in Kern County and of recent research in the same area.

The scientists tested blood specimens from 203 human patients who were hospitalized with encephalitis symptoms indicating damage to the central nervous system. Blood tests showed some of these patients were infected with western equine and St. Louis encephalitis viruses, the former predominating.

More than ten thousand insects were gathered, including mosquitos. From these, 31 strains of western equine encephalitis virus were taken, while one new virus was found. Twenty-eight of the 31 strains were from Culex tarsalis, a common mosquito.

Walter Jarvis Barlow Society for the History of Medicine.—The late Dr. Walter Jarvis Barlow of Los Angeles, was the founder of the Barlow Sanatorium and also of the Barlow Medical Library (the latter since amalgamated with the library of the Los Angeles County Medical Association.)

In his memory a group of Los Angeles colleagues added to their group on historical studies, his name. A recent announcement gives the following information:

The Walter Jarvis Barlow Society for the History of Medicine, invites members of the Los Angeles County Medical Association to meet with them in the Library of the Association on Thursday evening, January 24.

Herbert N. Evans, M.D., director of the Institute of Experimental Biology of Berkeley, California, will be the speaker for the evening. His subject will be: Bernardo Houssay, Argentine Physiologist. This will be abundantly illustrated with lantern slides.

The meetings will be called to order at 8:00 p.m.

Disease Prevention Week Again Scheduled.—Disease Prevention Week, introduced last year, again will be observed February 17-24 in Los Angeles city and county.

The event will be conducted by the association in co-operation with city and county health departments and social and welfare agencies.

Inoculations to prevent whooping cough, diphtheria and smallpox, and tests to determine presence of tuberculosis, syphilis and gonorrhea will be urged. When the latter infections are detected, victims will be advised to start treatments promptly.

An exhibit in the county museum, Exposition Park, will show latest methods in combatting the six ailments.

American Urological Association: Urology Award.—The American Urological Association offers an annual award "not to exceed $500" for an essay (or essays) on the result of some specific clinical or laboratory research in Urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. All interested should write the Secretary, for full praticulars.

The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Netherland Plaza, Cincinnati, Ohio, July 22-25, 1946.

Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before July 1, 1946.

Prize Contest in Obstetrics.—The American Association of Obstetricians, Gynecologists and Abdominal Surgeons Foundation announces that the annual prize contest will be conducted again this year. For information address: Dr. Jas. R. Bloss, Secretary, 418 11th Street, Huntington 1, W. Va.

Lasker Foundation Awards $500.—An alert, eighty-five year old scientist, Robert Latou Dickinson, M.D., one of the country's leading gynecologists and obstetricians, and Virginia's progressive State Health Commissioner, Irl Cephas Riggin, M.D. will be the recipients of the 1946 Albert and Mary Lasker Foundation awards for the most significant contribution to research in human fertility, and for meritorious public health service.

Dr. Dickinson has devoted more than a quarter of a century to furthering knowledge about human fertility and its control, as gynecologist, anatomist, educator, scholar and artist.

Dr. Riggin, who is also president of the Association of State and Territorial Health Officers, has led Virginia in becoming the seventh state in the Union to make planned parenthood services available as part of the state's Public Health Program of maternal care. The program he has initiated includes noteworthy coöperation between the Virginia League of Planned Parenthood and the State Health Department, in making available a full time Public Health educator to interpret the value of planned parenthood throughout the state.

Penicillin for European Countries.—The drug, penicillin, will be continuously available in several European countries as result of arrangements which are being made by the United Nations Relief and Rehabilitation Administration, in coöperation with the Canadian government, it was announced on January 11, 1946, in Washington.

In at least three countries, and possibly more, the governments will set up plants to manufacture the drug, under plans obtained and supplied by United Nations Relief and Rehabilitation Administration (UNRRA) and this agency will supply necessary component parts for the manufacturing process.

Czechoslovakia, Poland, and Yugoslavia will set up the first plants, under government ownership and operation, and other countries may join in the program later, though this has not yet been decided. The plans supplied by UNRRA to the countries are designed to implement production of 15 to 20 billion units of the drug each month from each factory.

Dr. I. V. Sollins, of UNRRA's medical and sanitation supplies division, completed arrangements on behalf of the three governments which will establish the plants.

The entire project is an international one. The plans were obtained through coöperation of a Canadian laboratory now manufacturing penicillin. The vats, tanks, and other component laboratory parts will be obtained by UNRRA in the United States. The three governments will obtain or erect the necessary buildings.

The reason the governments requested the aid in setting up the plants is that they fear that when UNRRA ceases operation at the end of 1946 that they will be cut off from penicillin supplies.

The Canadian plant, where the European government representatives will be trained is close in both size and technique to the ones which the Polish, Czechoslovakian and Yugoslavian governments will establish. Thus, the training will prepare the European scientists to get the plants in their countries under way with a minimum of difficulty.

When commercial production of penicillin first started, the molds from which the drug is derived were raised in flasks and the plants contained thousands of them. Since that time, newer methods have been developed and now large vats have been substituted for the innumerable small flasks. UNRRA will supply the vats and the extraction apparatus as its part of the program.

UNRRA engineers and scientists are now at work on procurement of the necessary component parts for the European establishments so that they may be purchased and shipped to arrive in Europe by the time the governments there prepare the buildings for them and the trained personnel returns. The joint international plans call for the government plants to be in operation by the end of 1946.

National Gastroenterological Association 1946 Award Contest.—The National Gastroenterological Association announces the establishment of an Annual Cash Prize Award of $100 and a Certificate of Merit for the best unpublished contribution on Gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy

All entries for the 1946 prize should be limited to 5,000 words, and must be received not later than May 1, 1946. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

New Anti-Flu "Shots" Success, Army Reports

Washington, Jan. 12.—(AP.)—The Army's new anti-flu "shots" are producing encouraging results, the Surgeon General reported on January 12.

Preliminary indications, he said, are that the wartime-developed vaccine has reduced the incidence of influenza among men in uniform.

At the same time the U. S. Health Service reported that for the third successive week civilian influenza cases have declined from a peak of 148,688 in the week ended December 15.

Early in the fall the Army began vaccinating 7,000,000 men with a war-developed vaccine made from killed viruses of influenza "A" and "B," the two most common types.

Officers said reports so far show that "the incidence has been lower than what we might ordinarily have expected during an outbreak."

They declined to give specific figures.

In tests conducted before the mass vaccination the new material reduced the incidence of flu by about 75 per cent among those vaccinated with it, as compared with unvaccinated persons.

The U. S. Public Health Service announced that the number of cases reported throughout the nation for the week ended January 5 had dropped to 47,273.

"The indications are," declared an official of the health service who asked anonymity, "that both the incidence and mortality of the disease in the current outbreak are on the decline and that while the total number of cases may prove eventually to be comparable to the number in the epidemic of 1943-1944, the evidence is that the disease has not been so severe as it was then."—Los Angeles *Times*, January 13.

U. S. Population Up 8,000,000 In Five Years

Washington, Jan. 15.—(AP.)—The Census Bureau said on January 15, that during the five years ending July 1, 1945, the population of the United States including armed forces overseas, increased by 8,000,000. Population as of that date was 139,621,431.

The increase, which the bureau attributed to the wartime rise in the birth rate, was about 10 per cent less than the increase for the 10-year period from 1930 to 1940. Another cause for the increase was the excess of arrivals of citizens and aliens over departures, the net immigration totaling nearly 600,000 in the five-year period.—San Francisco *Chronicle,* January 16.

Population Estimates for California Counties: 1940 Census and 1946 Estimates

(COPY)

CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH

County	Census April 1940	Preliminary January 1946
Alameda	513,011	743,000
Alpine	323	250
Amador	8,973	7,700
Butte	42,840	52,100
Calaveras	8,221	9,000
Colusa	9,788	9,800
Contra Costa	100,450	257,000
Del Norte	4,745	4,000
El Dorado	13,229	13,800
Fresno	178,565	225,000
Glenn	12,195	15,100
Humboldt	45,812	51,900
Imperial	59,740	55,800
Inyo	7,625	9,700
Kern	135,124	184,000
Kings	35,168	41,800
Lake	8,069	10,000
Lassen	14,479	18,000
Los Angeles	2,785,643	3,584,000
Madera	23,314	30,600
Marin	52,907	76,200
Mariposa	5,605	4,100
Mendocino	27,864	32,300
Merced	46,988	53,200
Modoc	8,713	9,600
Mono	2,299	1,300
Monterey	73,032	100,000
Napa	28,503	42,700
Nevada	19,283	18,400
Orange	130,760	170,000
Placer	28,108	31,700
Plumas	11,548	10,400
Riverside	105,524	138,000
Sacramento	170,333	219,000
San Benito	11,392	13,000
San Bernardino	161,108	226,000
San Diego	289,348	481,000
San Francisco	634,536	800,000
San Joaquin	134,207	190,000
San Luis Obispo	33,246	43,400
San Mateo	111,782	183,000
Santa Barbara	70,555	87,000
Santa Clara	174,949	229,000
Santa Cruz	45,057	55,000
Shasta	28,800	26,300
Sierra	3,025	2,400
Siskiyou	28,598	28,500
Solano	49,118	127,000
Sonoma	69,052	85,200
Stanislaus	74,866	112,000
Sutter	18,680	24,100
Tehama	14,316	15,600
Trinity	3,970	3,150
Tulare	107,152	131,000
Tuolumne	10,887	10,300
Ventura	69,685	90,000
Yolo	27,243	34,000
Yuba	17,034	23,600
STATE TOTALS	6,907,387	9,250,000

Above statistics prepared by California Taxpayers' Association, "The Tax Digest," January, 1946.

U. C. Enrollment Again Tops U. S.

With a total enrollment of 18,977 full-time students, the University of California—including the Los Angeles, Berkeley, Davis, San Francisco, Mt. Hamilton, Santa Barbara, Riverside and La Jolla campuses—is again the largest institution of higher learning in the United States, it was announced on January 13 by Registrar William C. Pomeroy.

His assertion is based on figures compiled recently by Dr. Raymond Walters, president of the University of Cincinnati, who makes an annual survey of more than 600 colleges and universities.

While college and university enrollments throughout the United States showed a 16 per cent increase, the University of California showed a 26 per cent increase over 1944.

The University of California figures, taken at the close of the enrollment period, includes 10,224 students on the Berkeley campus, 6,826 on the Los Angeles campus and the remainder on the other six campuses in the State.

On the Los Angeles campus there are 530 grdauate students and 6,296 undergraduates; at Berkeley there are 1,628 graduate students and 8,596 undergraduates. Roughly these totals are 30 per cent men and 70 per cent women.—Los Angeles *Times,* January 14.

Mother's Milk Bank Will Be Established in San Francisco

A San Francisco baby who needs mother's milk, but whose own mother is not able to give it to him, will soon have a better chance to grow into a sturdy youngster.

Plans have been virtually completed by the baby hygiene committee of the San Francisco Bay branch, American Association of University Women, for the establishment of a mother's breast milk bank. It will be financed by the women's group and operated in space donated by Children's Hospital.

"The milk will be collected from mothers who have a surplus, and distributed upon prescription to sick and premature babies," according to Mrs. Paul Dulfer, project chairman.

"It will probably be collected in the home by the bank's personnel and brought to Children's Hospital, where the bacteriological count will be taken. It will be stored at the hospital and distributed from there."

There are two ways to preserve the milk, Mrs. Dulfer explained. One is by canning and the other is by freezing. As yet it has not been decided which method is to be used here.—San Francisco *News,* January 9.

An Old Institution

Prostitution, as has been remarked from time to time over several thousand years, is an old institution. In the west it has been slowly receding over the millenniums because it is incompatible with social progress in the largest sense. Its recession among Americans and many other western peoples has been in ratio with the progress of social education.

Whether Americans can abolish the institution all over the world, or even modify it, is another matter entirely. We doubt if General MacArthur is going to have any great success in his newest effort to abolish licensed prostitution in Japan, where it has for many centuries been traditionally geared with the national economy and the social outlook. It is "an experiment noble in purpose," but we predict the experiment will fail.—Editorial in San Francisco *Chronicle,* January 28.

Dread Diphtheria Microbe Staging Comeback As Deaths Show Increase in U. S., Europe

San Francisco.—(AP.)—The diphtheria microbe, which had been all but knocked out by preventive medicine at the outbreak of World War II, may be staging a comeback, according to Dr. J. C. Geiger, San Francisco health director.

Although there has been no great increase in the number of cases, the fatality rate has about doubled in the last year in San Francisco, Dr. Geiger said, in an article in the *Archives of Pediatrics.*

He also cited figures showing increased fatalities elsewhere in the Pacific and Mountain States. Deaths have increased, too, in all parts of the country excepting the Atlantic States.

The diphtheria organism now is hitting more adults than formerly, particularly those 30 years of ago or older. This fact, plus the evidence of its suddenly increased virulence, suggests that it may have evolved into a new type of microbe better able to resist preventive serums, Dr. Geiger said.

Surveys by the American Medical Association. showing significant increases in the number of diphtheria deaths in 1941 and 1942, said war travel may have been an influence and that the reduction in the amount of available medical care among civilians may have had something to do with it.

Dr. Geiger, referring not only to the increase in this country but also to UNRRA reports of 2,000,000 diphtheria cases and 100,000 deaths in Europe in 1943 and 1944, urged that efforts be made to maintain an adequate immunization program and that a scientific hunt be undertaken to determine whether a new type of microbe is at work and whether more effective serums and vaccines can be developed to fight it.—Sacramento *Union*, January 20.

"Quarterly Review of Pediatrics."—This new publication brings off its first issue in February, 1946. Its Foreword states:

"Medical articles of pediatric interest are almost beyond count. Even the most energetic and polylingual reader would find it well-nigh impossible to seek out and critically evaluate, without outside aid, every new contribution in this expansive specialty. The prime function of the *Quarterly Review of Pediatrics* is to make it feasible for the busy physician to keep abreast of the most recent progress in all branches of pediatrics with a minimum of time and effort. The *Quarterly Review of Pediatrics* serves also as an authoritative guide to original sources when more detailed information is desired.

"From a great diversity of national, state and special journals in this country and abroad the editors select for abstracting, as promptly as possible, all articles of significance which deal with disease conditions, health, growth, and mental welfare, from infancy through adolescence. These abstracts are prepared by trained bibliographers, mostly physicians. The editors check over advance copies of each abstract and add interpretive or critical comments whenever thought necessary."

Further information follows:

"Issues of the *Quarterly Review of Pediatrics* appear in February, May, August and November. Each number is thoroughly indexed, and a cumulative index for each volume is included in the November number. The "Bookshelf" department reports on all new books the pediatrician should know about, as soon as they are brought to editorial attention.

"Thus within the covers of a single journal there will be found a résumé of pediatric progress, well-organized, concise, up-to-date, and complete. It is hoped that these abstracts and book reviews will stimulate the pediatrician and student to study the unabridged originals of all which excite his interest.

"Suggestions and comments from our readers will be gratefully received.

"Address communications to Irving J. Wolman, M.D., *Editor-in-Chief*, The Children's Hospital, 1740 Bainbridge Street, Philadelphia 46, Pa.

Human Voice Heard 20 Miles in Arctic

Los Angeles, Jan. 31,—In the cold, clear air of the Arctic the sound of the human voice may be heard up to 20 miles; but in the hot, dry California desert speech becomes inaudible in a few hundred feet.

So said Dr. Vern O. Knudsen, professor of physics on the Los Angeles campus of the University of California, in reporting to the American Physical Society the effects of humidity and temperature on the propagation of sound in the atmosphere.

Dr. Knudsen and his assistants are conducting research at the present time to determine the influence of atmospheric conditions on sound—such as fog, smoke, pollen in the air, etc. Fog, for example, has been found to absorb considerable sound, especially that of high pitch.

Such experiments may be put to use in a practical way in the designing of large auditoriums and radio studios, installing public address systems, testing of acoustical materials for homes and offices and operation of sound signaling and sound ranging equipment by the Army and Navy.—U. C. *Clip Sheet.*

Representative J. H. Tolan of Oakland

Representative John H. Tolan told the *News* by telegram from Washington this morning that he does not intend to run for reëlection.

Representative Tolan, Democratic Congressman from Oakland, said:

"In view of the early primary filing date March 6, it seems only fair that I make known my decision that I do not intend to run for reëlection. It has been a great honor to represent my district in Congress for 12 years, and I shall always remember with deepest gratitude the confidence reposed in me by my people.[*] . . . San Francisco *News*, February 4.

MEDICAL JURISPRUDENCE[†]

HARTLEY F. PEART, ESQ.

San Francisco

Hospitals: Liability of Private Hospital for Acts of Nurse for Injuries Sustained by a Patient When Teapot of Hot Water Spilled on Her

Following the decision in *Wood vs. Samaritan Institution*, discussed in the November, 1945 issue of CALIFORNIA AND WESTERN MEDICINE, the California Supreme Court has very recently again enunciated the standard of conduct required of a hospital in the care of its patients.

In *Rice vs. the California Lutheran Hospital*, 27 A.C.A. 310 (December 4, 1945), the plaintiff brought suit against the defendant, a private hospital, for injuries sustained by her when hot water and tea, placed on a table at her bedside spilled over onto the bed scalding her. On the trial, judgment in favor of the defendant hospital was entered by the court.

Plaintiff, on the recommendation of her physician, had entered the defendant's hospital as a patient on Thursday, October 8, 1942, for an operation consisting of the removal of her uterus which was affected with cancer. She was put to bed, where she remained until the following Saturday morning when the operation was performed, the operation required an abdominal incision four or five inches long, and extended over a period of an hour and forty-five minutes. A spinal anesthetic was administered prior to the operation and occasionally during the progress of the operation nitrous oxide was given to the plaintiff.

At the time of the injury plaintiff's room was equipped with a table standing about a foot from the left side of the bed, the top of which was approximately six inches below the level of the bed. On the Monday following the operation while plaintiff was alone in her room, an employee of the hospital brought a tray with a teapot of hot water, a cup and saucer, a spoon and a tea bag which she placed on the bedside table. She left immediately. Later a nurse noticed that the call light at plaintiff's door was on and entered her room. She found the teapot and cup and saucer on the bed. The tray was on the bedside table. Plaintiff had suffered burns on her arm and breast. The nurse had been instructed in the morning by the doctor to serve plaintiff hot tea.

To support the judgment of the lower court, defendant urged that there was no substantial evidence of negligence; that plaintiff was contributively negligent and assumed the risk; that even if serving the tea constituted negligence, plaintiff's physician alone was liable, as defendant hospital was merely following his instructions.

The California Supreme Court then stated that "a private hospital owes its patients the duty of protection, and must exercise such reasonable care toward a patient as his known condition may require." Then the court, applying this standard of conduct to the facts of the case at bar, found that there was sufficient evidence for the jury to find negligence on the part of the defendant.

The court, in this case, seemed to place emphasis on the facts that the plaintiff was about 60 years of age and that the operation was a serious one requiring nearly two hours to perform and severely taxed the strength of the patient. Also that only approximately 48 hours transpired between the operation and the injury. Further that no drinking tube was furnished with the hot water and tea, nor did the employee serving it tell the plaintiff that the water was hot.

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[*] CALIFORNIA AND WESTERN MEDICINE for November, 1945, on pp. 239-242 printed excerpts from the statement of Congressman John H. Tolan of Oakland, in re: "Senate Bill 178 to Permit Chiropractors to Treat the Beneficiaries of the United States Employees' Compensation Act."

[†] Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

The court stated in its opinion that the defendant either knew or should have known of plaintiff's condition; that it would be dangerous to leave the hot water and tea on the bedside table without any facility for drinking it, such as a tube, and without any safeguards or attendants and that a hazard had been created that would probably result in an injury to plaintiff.

In discussing the circumstances leading to the accident the court held against the defendants' contention that the plaintiff was contributively negligent reasoning that she may have assumed, as a person of ordinary prudence, in a half conscious fashion so soon after a serious operation, that it was safe to attempt to consume the tea, not realizing the danger incident thereto or the extent of her weakness.

As to the defendant's argument that if anyone was liable it was plaintiff's physician, who gave the order that the tea be served, the Supreme Court stated, "If the duty of care resting upon the hospital embraced the serving of the tea, defendant cannot escape the responsibility for performance of that duty by attempting to shift it to the doctor. The doctor merely fixed the time when tea could be served to the patient, he did not purport to supervise the care and supervision to be exercised in the process of serving it. Even if he ordered the tea to be served in the customary manner, but that manner was negligent, the defendant would be liable in following such instruction where a duty of care toward the patient rested upon it." Then in its discussion the court continued saying, "it cannot be said that because the doctor ordered tea to be served plaintiff, he was making the nurses and the server of the tea his servants and employees to the exclusion of defendant hospital as the employer. The hospital still had direction and control over its employees and was responsible for the care to be observed by them in the process."

Using the above reasoning the court held that even though the giving of the order that tea be served was a part of the medical treatment, still the serving thereof and the care and attention in connection therewith were part of the duties assumed by the hospital and were not a part of the medical treatment and concluded that liability could not be shifted to the plaintiff's physician.

The California Supreme Court then reversed the judgment and directed the trial court to enter a judgment for the plaintiff against the hospital.

A Program of Health Legislation Beneficial to the People

At a conference of presidents and other officers of constituent state medical societies held in Chicago on December 2, 1945, resolutions which appear below were approved and referred to the A.M.A. Council on Medical Service and Public Relations and to the House of Delegates of the American Medical Association on December 5, 1945.

Resolutions follow:

A Program of Health Legislation Beneficial to the People

Whereas, It is the earnest desire of the medical profession of this country to provide better health care for the American people and improve health facilities and standards, therefore be it

Resolved, That the following principles for a health legislation program be adopted:

1. Establishment in the President's Cabinet of a Secretary of Public Health and Medical Welfare, who shall be selected from the ranks of actively practicing physicians, and under whose jurisdiction every Federal bureau and office, whose duties are related to health and medical welfare, shall be grouped.

2. Encouragement of medical and other scientific research and study for the continuous improvement of medical care, by government grants-in-aid.

3. Provide Federal and state loans, or guarantees of private loans, for the expansion of hospital and educational facilities, the operation of same to be entirely supervised, controlled, and carried on by those who own such facilities and by the medical profession.

4. (a) Establish state-wide voluntary non-profit health care programs, in every state, based on the free choice of purveyers of health care; such programs shall act as a service plan to all in groups classified as within a special income level as determined by the plan in each state or regional unit; as an indemnity plan for those classified as above that income level by each state or regional unit; as a service plan to the indigent and semi-indigent by contractual arrangement for payment of charges from county, state or Federal funds; as a service plan for all other governmental categories eligible for health care; as a service plan for all physicians' services to veterans of the armed forces for all illnesses or disabilities eligible under the law.

(b) Any further Federal or state programs for expansion of medical service to be developed within the structure of the above described program.

(c) National coöperation with the proposed plans of Major General Paul R. Hawley of the Veterans' Administration in the therapeutic administrations to veterans for service-connected disabilities. Also for the development of veteran facilities as teaching hospitals under the medical direction of civilian consultants in the respective specialized medical departments.

(d) All state-wide medical care programs on either a service or indemnity care basis shall be incorporated under special state enabling acts or by already existing state statutes relating to non-profit producers' coöperatives. This will provide for either a pre-payment or a reimbursement contractual service.

(e) Group coöperation and reciprocity, on a national level, by all voluntary state medical and hospital care (Blue Cross) programs, should be accomplished.

5. We suggest establishment in communities where feasible of a public information and educational service adequately financed, to advise all the people with respect to proven measures to prevent illness, hygienic and sanitary measures, and where to go to seek help when ill or injured.

6. The function of government, Federal and state, should be to encourage and assist, rather than to compete with, reputable voluntary health insurance plans, and be it further

Resolved, That every state medical society be invited to study, adopt and activate these principles on the state level, and that they be submitted to the A.M.A. Council on Medical Service and Public Relations for immediate consideration as a pattern for a national health program.

How Convention Dollars Are Allocated

In connection with the C.M.A. session in Los Angeles in May, and A.M.A. meetings in San Francisco, July, 1946, the following information may be of interest:

Breakdown of the convention dollar varies, but an average of 14 cities' estimates (in cents) is fairly typical:

Hotel room and incidentals	27.11
Hotel restaurants	12.75
Other restaurants	10.79
Liquor	6.29
Department and other stores	16.12
Taxis and transportation	3.52
Theater	2.34
Other amusements	8.64
Gas, oil and car service	1.81
Wholesale and manufacturing	3.98
Other items	6.65

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIX, No. 2, February, 1921

EXCERPTS FROM EDITORIAL NOTES

Annual Meeting in San Diego.—It is about time to begin planning for the annual trek to the meeting of the Medical Society, State of California. The war is really over. The arts of peace are flourishing. In scientific, social, and practical value, the approaching session already bids fair to eclipse any of its predecessors. There are some big problems to be reported on and some decisive lines of action to be determined. There ought to be two thousand doctors in attendance. It is worth it. For once, put yourself in the way of realizing that you belong to a big, upstanding, two-fisted profession. Get out of your rut. You are in one, whoever you are. Get out of it. Ruts hinder, and your perspective is curtailed by them. . . .

Board of Medical Examiners Abolished by Assembly Bill 347.—On January 18, 1921, Governor William D. Stephens sent a special message to the Legislature setting forth, in general terms, an economy and efficiency program. . . .

In the Governor's message what was referred to as "the seventh bill" to create a "Department of Professional Standards" was itnroduced as the first bill of the eight Efficiency Economy Bills in numerical order. We are not informed whether this was an accident, or whether it is considered of first importance, and should therefore be first considered. . . .

The chief purpose of the Board of Medical Examiners is to test the qualifications of those who undertake to treat disease in any form and to protect the public from unskilled and incompetent practitioners, from imposition by charlatans and quacks who make extravagant claims of ability to cure the sick and are a constant menace to the health of their victims and the community at large. The public as a whole is entitled to know that anyone licensed by the state for a profession which requires the highest skill, learning and character shall have these qualifications determined by competent judges, and that the incompetent and unscrupulous shall be excluded from practice no matter how loudly they clamor. No law must be passed for political expediency that will lower standards, admit the uneducated to practice, and thereby jeopardize the public health.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Concerning the Size of Women: Preliminary Note with Special Reference to Height," by Clelia Duel Mosher, M.D., Stanford University, Palo Alto, Calif.—A popular belief seems to be prevalent that women are increasing in size. This idea has, apparently, received some confirmation from the study of 4,023 of the Stanford women who entered the University during the past thirty years. . . .

The romantic story of the founding of Stanford University gave its opening in 1891 a very wide publicity and

(Continued in Front Advertising Section, on Page 24)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.

Secretary-Treasurer

News

"Judge Charles K. Dyer, fined Phillip V. Abrams $200 and suspended a thirty day sentence of the doctor found guilty of falsifying a birth certificate and aiding 'sale' of an illegitimate baby to a childless couple." (Pasadena, California *Star-News*, October 31, 1945).

"Special Agent Joseph Williams of the Board of Medical Examiners filed a complaint charging Dr. Otto Adolph Schmitt of Brookings with the illegal practice of medicine. . . . Dr. Schmitt did take a California examination for a medical license but failed to pass." (*Crescent City Triplicate*, November 27, 1945.)

"For the death of their infant son, Donald, following medical treatment, Donald S. McInnes, a marine engineer, and his wife, Ann, filed a suit for $50,250.00 damages in Superior Court against Raymond Fraher, 46, now serving a 180 day jail sentence for practicing medicine without a license." (*Los Angeles Times*, November 15, 1945.)

"Massage Parlor in Hollywood Raided."—"A Chiropractor and two girls were jailed as suspected morals offenders. Investigators said they were making a detailed check of the 'list of patients' in an effort to recover a possible white slavery ring. Doctor Proctor booked on suspicion of pandering, contended he was a 'bona fide' doctor and displayed the list of patients as proof." (*Hollywood Dispatch*, November 15, 1945.)

"The Veterans Administration, with the approval of General Omar N. Bradley, is undertaking a $1,000,000 program of research on artificial limbs. The move is prompted by criticism of the types now being supplied to veterans." (San Mateo, California, *Times Leader*, November 12, 1945.)

"District Attorney James Thueson today disclosed a trail of fraudulent morphine prescriptions which he said led to the suicide of Dr. Harold J. Cooper, 51, who swallowed poison after Thueson advised him by telephone to appear for arraignment." (San Dego, California, *Union*, November 8, 1945.)

"Two Fresno druggists pleaded guilty in the police court today to technical violations of the State Health and Safety Code arising out of the acceptance of narcotic prescriptions by telephone from Fresno physicians." (Fresno, California, *Bee*, December 7, 1945.)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members. Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

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Pavatrine with Phenobarbital provides both *neurotropic* and *musculotropic* spasmolysis—notably free from undesirable side effects—combined with mild central nervous sedation. Non-narcotic; orally administered.

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CURE IN CANCER WHEN TREATED EARLY

	Early	Late
Skin	95%	25% (?)
Lip	85-95%	10-30% (?)
Mouth	80%	20% (?)
Breast	75%	20% (?)
Uterus—body	75-80%	25% (?)
cervix	75-80%	15% (?)
Bladder	50%	0 (?)
Rectum	50%	0 (?)
Stomach	30-40%	0 (?)
Larynx	70-80%	0 (?)

Diagnose early by examination and biopsy with frozen section, and confirm by paraffin section.

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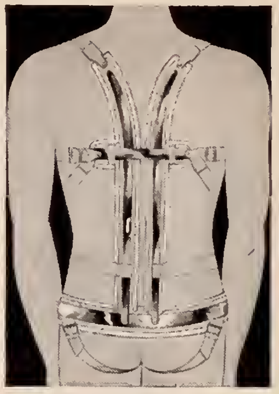

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Indicated for use following fracture of the spine or Pott's disease. Can be made of spring tempered duralumin or light flexible spring steel.

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TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 30)

these patients and the readiness with which they will submit to any procedure which offers some small hope of relief. . . .

From an Article on "Industrial Medicine," by Robert T. Legge, M.D., University of California, Berkeley.—For the first time in the history of this society a new section on Public Health and Industrial Medicine makes its debut on the program as an important branch in the field of scientific medicine. These specialties should be devoted in their fullest measure to educational problems in preventive, industrial and socialized medicine, so as to offer to the general profession a knowledge of subjects that are correlated with medicine. The practicing physician trained in curative medicine deals entirely with the individual while the sanitarian, the industrial physician, or the social worker deals with the problems that confront the whole of the society. All factors in public health or social economics are fundamentally medical subjects, and consequently the profession should be continually informed of the advances made in these fields of research. . . .

From an Article on "The Industrial Surgeon, What He Is—What He Can Be—What He Should Be," by Gilbert M. Barrett, M.D., F.A.C.S., San Francisco.—Many problems are before the medical world and the most of these are pressing for recognition and solution before the Industrial portion of the world.

The Industrial Surgeon of today believes in and advocates examination of all applicants for work. It should be the accepted routine of all industrial enterprises. One of the greatest sources of saving to the employer is the

(Continued on Page 40)

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• A complete milk diet that closely conforms to human milk... a nutritious food for infants that may be used either complemental to or entirely in place of human milk . . . well tolerated by both premature and full-term infants... a food that may be used from birth until the end of the bottle feeding period—without changing the formula... a diet that means a well-nourished, happy baby.

These are "end results" of the years of research back of Baker's Modified Milk.

What the attainment of these results means to doctors is attested by the steadily increasing use of Baker's Modified Milk, which is advertised only to the medical profession. More and more doctors are prescribing Baker's Modified Milk because they find Baker's produces desired results with less trouble in most cases of infant feeding... that no change in dilution is needed as the baby grows older (just increase the quantity of feeding) . . . and the possibility of errors—always present when formulas are prepared in the home—is avoided.

To prepare Baker's for feeding merely dilute it to the prescribed strength with water, previously boiled. Baker's is available in both powder and liquid forms. Formulas made from liquid Baker's are especially easy to prepare; in some cases, such as the lack of refrigeration in hot weather, or when traveling, the powder form is preferable.

Doctors and hospitals are invited to write for full information and samples.

• Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B_1 and D. Not less than 400 units of vitamin D per quart.

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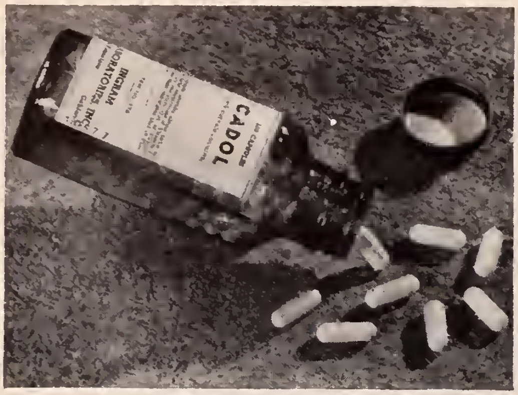

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Each CADOL Capsule contains

Bone Meal Po. Purif.	7½ grains
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(Equivalent to approximately 203 milligrams elemental calcium and 107 milligrams elemental phosphorus.)
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For parenteral calcium therapy use

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Mitigates discomfort of lips parched by fever or exposure. Contains intimate mixture of mineral oils and waxes — is non-irritating, protective, hypo-allergenic.

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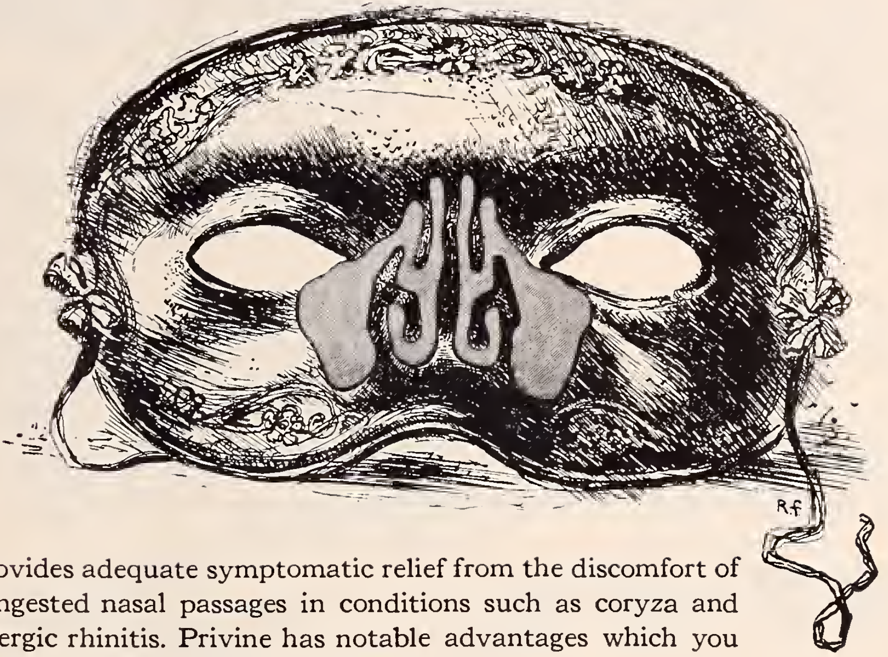

provides adequate symptomatic relief from the discomfort of congested nasal passages in conditions such as coryza and allergic rhinitis. Privine has notable advantages which you and your patients will appreciate:

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Privine, accepted by the A.M.A. Council on Pharmacy and Chemistry, is offered in two concentrations: 0.1 per cent, recommended for adults only; 0.05 per cent for children, also found effective in many adult cases. Your pharmacy can supply Privine in bottles of 1 oz. and 16 ozs.

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R. M. Tandowsky (American Heart Journal, January 1945) states: "The use of lanatoside C orally in preference to other preparations of digitalis seems reasonable because this drug acts with rapidity, yet with minimal toxic effect, and retains its pharmacologic potency in vivo for at least twenty-four hours. The effect of this drug has been demonstrated both electrocardiographically and clinically to be without variability, whereas other preparations of digitalis act with marked inconsistency. Furthermore, the toxic effects of this drug, when administered over a prolonged time, are less than those of other digitalis preparations in common use."

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Tablets, each containing 0.5 mg. of Lanatoside C
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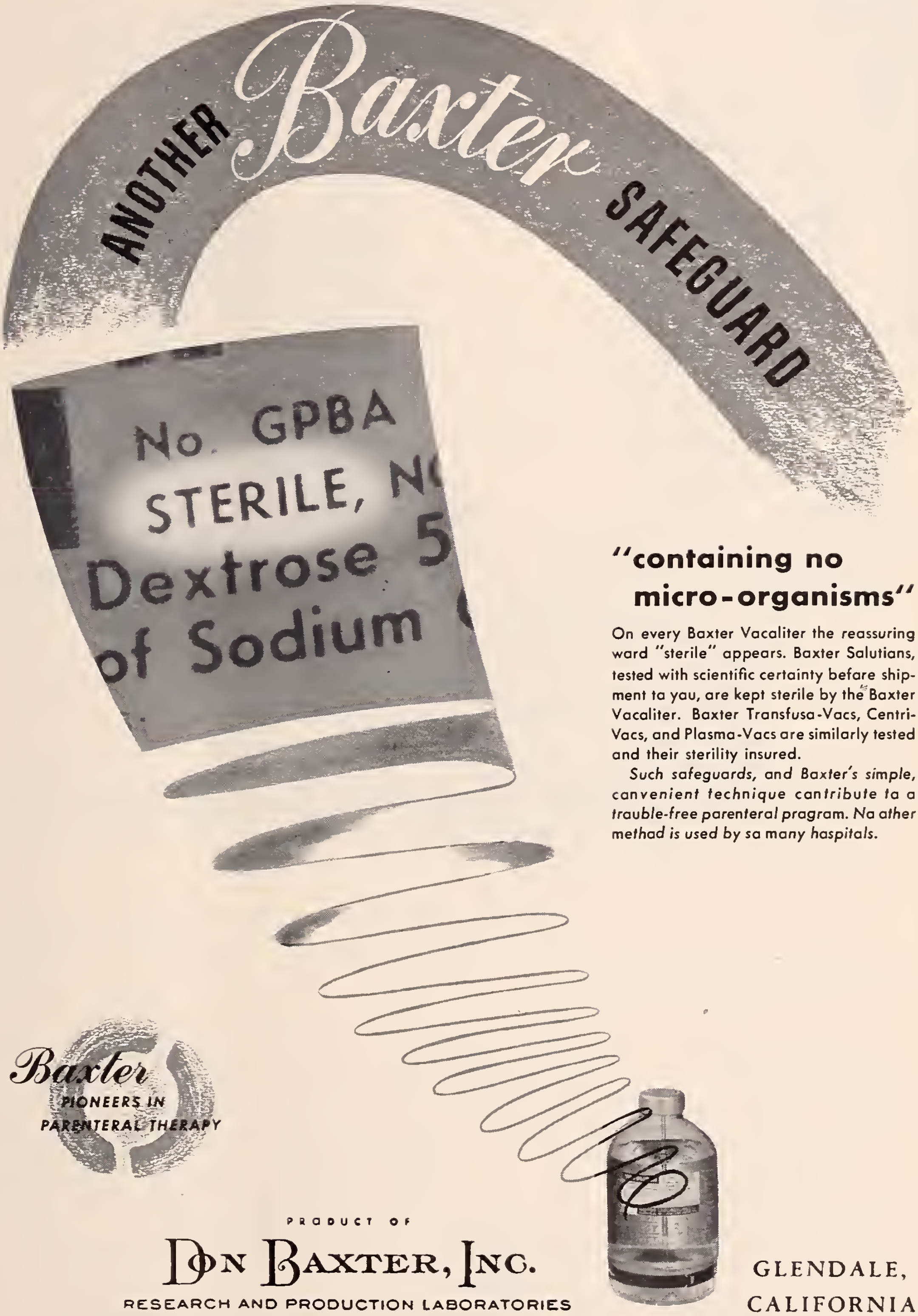

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On every Baxter Vacaliter the reassuring word "sterile" appears. Baxter Solutions, tested with scientific certainty before shipment to you, are kept sterile by the Baxter Vacaliter. Baxter Transfusa-Vacs, Centri-Vacs, and Plasma-Vacs are similarly tested and their sterility insured.

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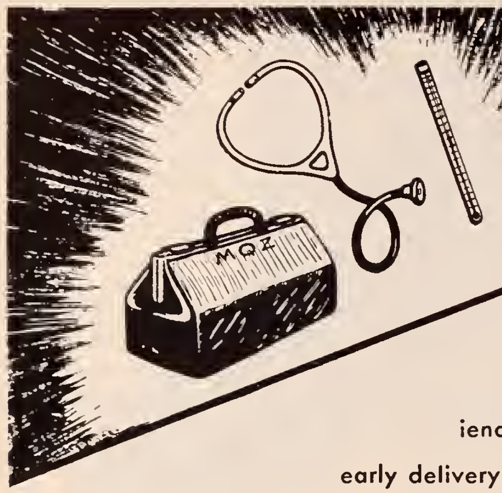

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TWENTY-FIVE YEARS AGO

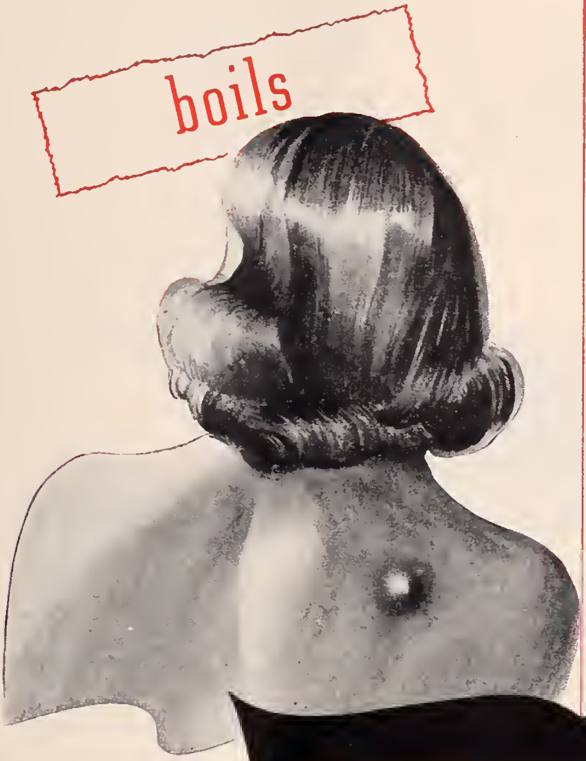
(Continued from Page 34)

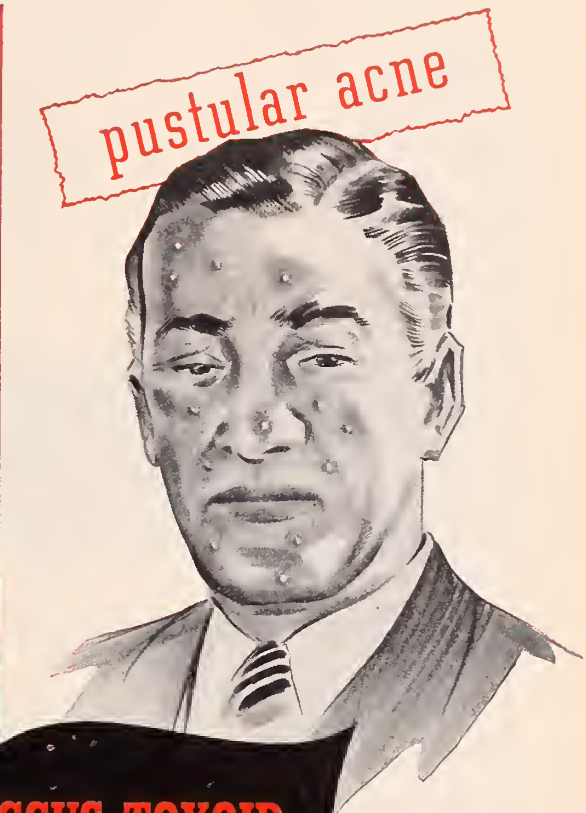
physical selection of employees for work. This is done by the physical examination of all applicants for work before employment. The value to the employer depends upon the thoroughness of these examinations and the amount of coöperation between the employment department, the medical department and the foreman. The placing of all comers on jobs without any effort at a physical selection for their work is responsible for a great financial waste which cannot be shown in dollars and cents, but which, nevertheless, is very evident. . . .

From an Article on "Deformities of the Hand Acquired After Accidents," by A. Gottlieb, M.D., San Francisco.—These hand deformities may be classified into three groups: hysterical, functional, and organic. A deformity is however rarely a pure example of a group in view of the fact that injury is their common etiology, and that they present symptoms which are characteristic for more than one group. . . .

From an Article on "Roentgen Treatment of Uterine Hemorrhage," by Lyell C. Kinney, M.D., San Diego, Calif.—The treatment of atypical uterine hemorrhage is the most satisfactory task referred to the radiologist. Most of these patients are seen after many months of bleeding, with severe anaemia, and frequently they have been curetted several times. In spite of this history the prognosis of a suitable case is almost invariable. It is practically certain that the bleeding can be controlled within four weeks and a rapid general recovery instituted by that time. The change in these women is little short of marvelous, and is most grateful to them and a

(Continued on Page 44)





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PITMAN-MOORE

AMONG the many conditions which especially enlist the sympathy of the physician—and tax his efforts to ameliorate the psychic as well as the somatic symptomatology—are boils and acne.

A growing literature reports the value of Staphylococcus Toxoid in the prophylaxis and therapy of various staphylococcic pyodermas and localized pyogenic processes due to *S. aureus* and *albus.* The toxoid induces the production of staphylococcus antitoxin in immunized persons, and there is accumulating evidence of its value in producing active immunity to the dermonecrotic and hemolytic elements of the toxins of *S. aureus* and *albus,* irrespective of the strain of the infecting organism.

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RECOMMENDED FOR TREATMENT AND PREVENTION OF

- Recurrent styes, boils, carbuncles
- Pustular acne associated with furunculosis
- Recurrent migratory staphylococcus abscesses of soft tissues and bone
- Staphylococcal infection of accessory nasal sinuses
- Other staphylococcal infections

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For the symptomatic relief of sinusitis…

"The benzedrine inhaler is an excellent vasoconstrictor and unless overindulged in, it may be used conveniently for long periods without deleterious results." Moore, J. H.: A Resume of Conservative Sinus Management, Southern Med. J. 34: 848-854

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The foundation is the thing!

Built on a *firm foundation,* the Leaning Tower of Pisa has withstood the centuries . . . so, too, health and vigor in infancy and the years ahead depend on a *firm foundation* of optimum nutrition. • BIOLAC, when supplemented with vitamin C, is a valuable infant food whose ample milk proteins constitute an adequate source of all essential amino acids . . . the indispensable *foundation stones* for sound tissues. • BIOLAC closely approximates mother's milk in safety, simplicity, and nutritional value.

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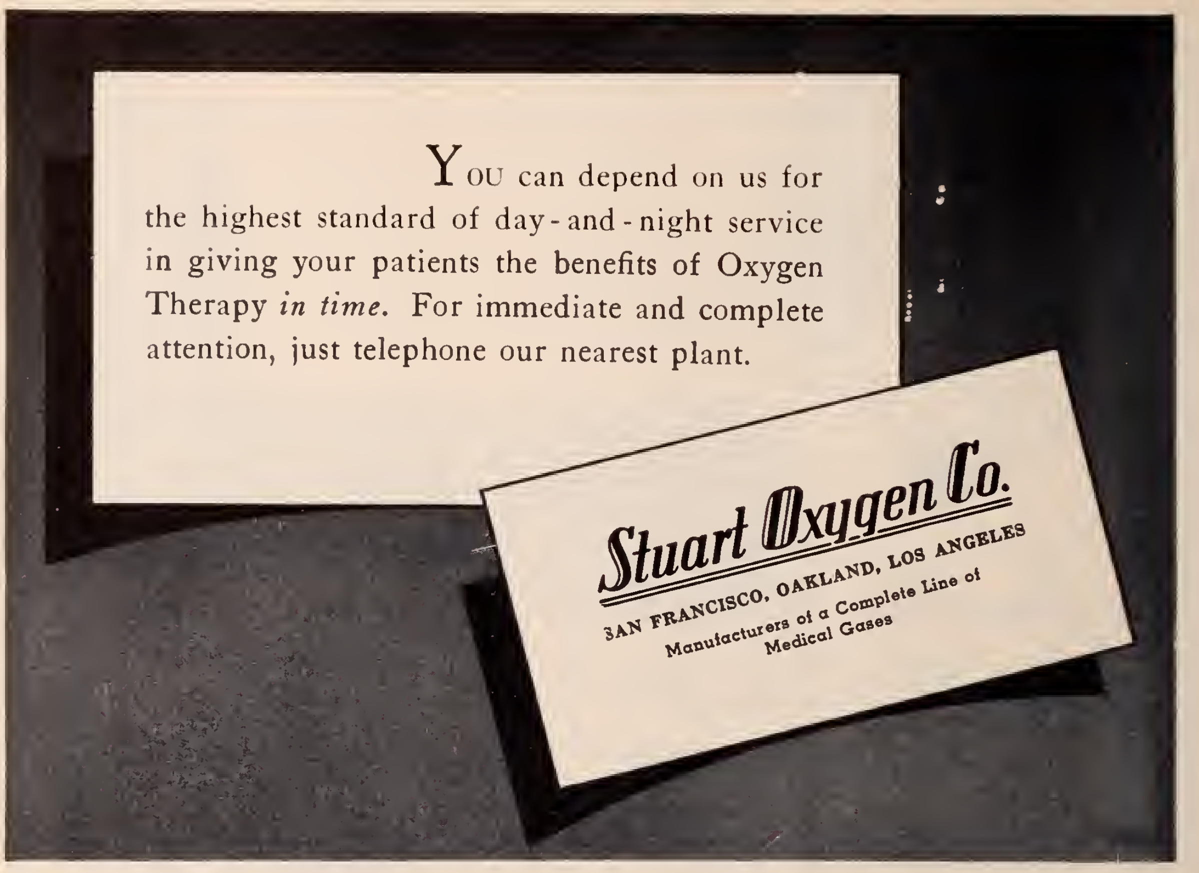
Quickly prepared . . . easily calculated: 1 fl. oz. Biolac to 1½ fl. oz. water per lb. of body weight.



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TWENTY-FIVE YEARS AGO

(Continued from Page 40)

source of great satisfaction to the attending physician as well as to the roentgenologist.

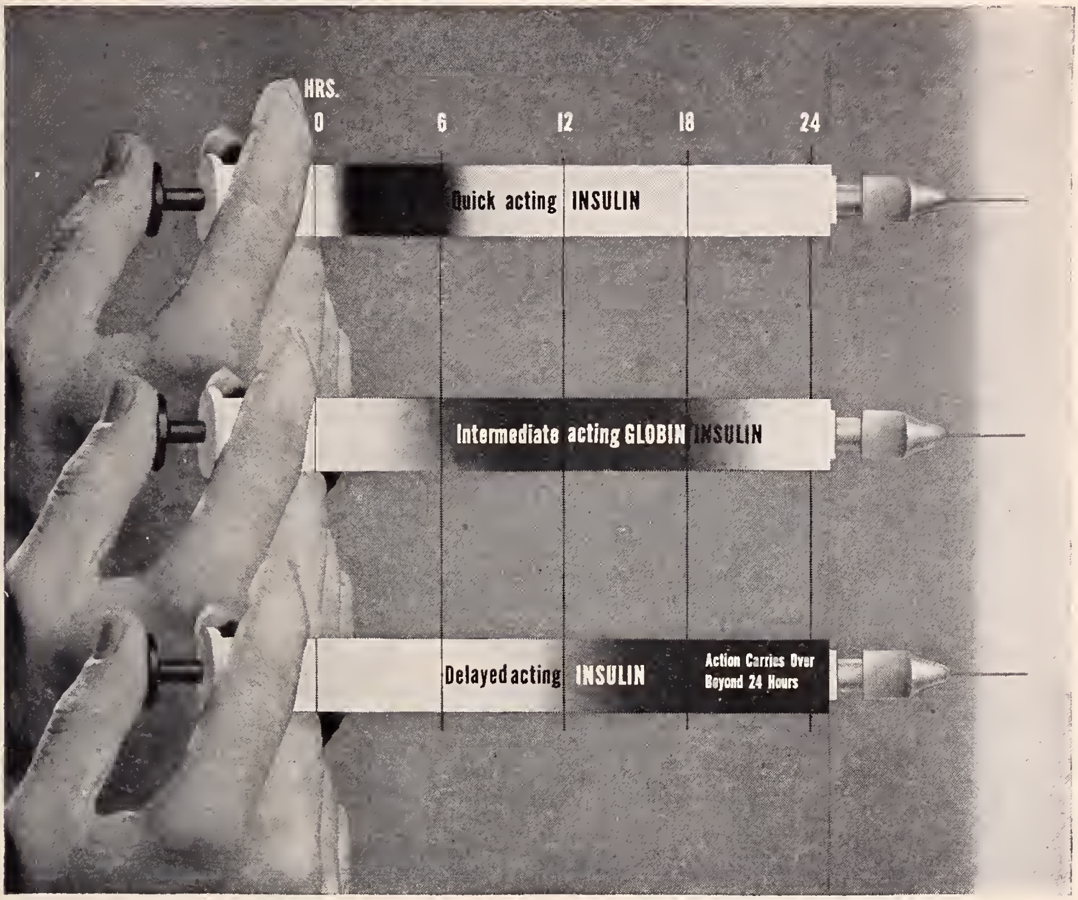
In spite of the brilliant results in properly chosen cases the *sine qua non* is an accurate diagnosis. Most of our patients are referred by gynecologists after careful study, and when they are referred otherwise they are thoroughly studied with a competent gynecologist. It is only under such painstaking coöperation between a pelvic surgeon and the roentgenologist that any actinotherapy is justified. . . .

From an Article on "Heat the Most Practical and Promising Treatment in Uterine Carcinoma," by J. F. Percy, M.D., San Diego, Calif.—Today we are limited in the discussion of the cancer question merely to the terms of its treatment. Practically nothing regarding any other phase of the disease is known, certainly not to a degree to be of any value in its management from the standpoint of therapy. The basis of all our treatment of cancer is still empiric, as it always has been, and yet it can truthfully be said that progress has been made, except possibly in the inoperable types as far as it relates to the use of the cold steel knife.

There are five methods today for the treatment of cancer that have a rightful claim to the consideration of medical men. They are the knife, x-ray, radium, electrocoagulation (diathermy), and heat. All five of these in the hands of those most familiar with their correct and rational use have undoubted cures to their credit, and I say this with full appreciation of the significance of the word "cure" as it is related to the question of scientific accuracy especially in the treatment of cancer. . . .

(Continued on Page 46)

Your 3 choices when treating diabetics...



WHEN A PHYSICIAN decides that a patient needs more than diet to control diabetes, he can now choose from three types of insulin. One is quick-acting and short-lived. Another is slow-acting and prolonged. Intermediate between these, is the third—the new 'Wellcome' Globin Insulin with Zinc. Its action begins with moderate promptness yet is sustained for sixteen or more hours—adequate to cover the period of maximum carbohydrate ingestion. By night, activity is sufficiently diminished to decrease the likelihood of nocturnal reactions. Physicians who consider the many advantages of this new third type of insulin now have another effective method of treating diabetes.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its relative freedom from allergenic properties. Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc., and vials of 10 cc., 40 units in 1 cc. Literature on request. 'Wellcome' trademark registered.

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Fully approved by the American College of Surgeons and the American Medical Association for Resident and Interne Training.

TWENTY-FIVE YEARS AGO

(Continued from Page 44)

From an Article on "Nastal Catarrh," by C. A. Phelan, M.D., San Francisco.—Catarrh, from the latinized form of the Greek word, "catarrhus," is a generic term used to denote the sort of fluid flow discharging from a membranous surface. This may be a simple serous or sero-mucous, mucous, muco-purulent, or a sanious catarrh, and the ratio of seriousness is placed in the above order. A catarrh may be acute, subacute or chronic, with more or less fever.

As applied to the nasal region, catarrh is not a disease but only a symptom, and may be a manifestation of a systemic condition, sometimes of the simplest and sometimes of the most serious. . . .

Dear Doctor:

- **Read the advertising pages**
  - **Show your interest by correspondence and patronage**
    - **Support those firms who advertise in your state Journal**

From "Chairman's Address: Advance in Business Methods, by P. A. Jordan, M.D., Eye and Ear Sec., San Jose.—Thirteen months have rolled by since last we met on these beautiful grounds. . . .

Chronic otitis media, we believe, will be much less in the growing generation of children than formerly, due to the growing custom of the careful enucleation of tonsils and adenoids.

The great advance in the science of our specialty has caused a tendency on the part of many of our fellows to attempt an improvement in the business methods of their own respective offices. There is no more excuse for lax business methods in our offices than there is excuse for poorly made diagnoses or carelessly administered treatments. Our patients, unfortunately, have been trained in past generations to consider the doctor as a man having no business methods, and this is, unfortunately, largely true. . . .

(Continued on Page 48)

ALLERGY is the nettle often near the rose of feminine attractiveness. But those sensitive to ordinary lipsticks need not foresake "feminine vanity, that divine gift which makes woman charming". • For ALMAY—makers of fine hypoallergenic cosmetics — provide in their lipstick a truly fine preparation (in 8 shades) which can be safely used by the majority of allergic patients. Base, indelible dye, perfume and coloring matter have been especially selected from ingredients known to involve the least danger of sensitization. • In cases of allergy to perfume, or to tetrabromofluorescein—ALMAY Unscented Lipstick and Lipstick without Indelible Dye are available. For hyperallergic patients, ALMAY Raw Material and Clinical Testing Sets may be obtained gratis, and individualized lipsticks developed.

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For 32 years Calso Water, prescribed by American physicians, has helped thousands of men and women to live more comfortably because of its beneficial effects in the treatment of arthritis, rheumatic and genito-urinary ailments. Also successfully used in all conditions of hyperacidity, toxemia of pregnancy, pre- and postoperative treatment; as well as during and following Sulfa and Penicillin therapy.

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4 color graph on Menstrual Cycle free on request.

TWENTY-FIVE YEARS AGO

(Continued from Page 46)

Excerpts from County Societies:

* * *

Alameda County Items.—The regular monthly meeting of the Alameda County Society was held at the Health Center Monday evening, December 20th. . . .

Dr. Dudley Smith, president of the League for the Conservation of Public Health, in token of their high esteem for him personally, and as a mark of their appreciation of his noble efforts for the advancement of public health, was presented with a gold watch bearing an appropriate inscription. Although taken by surprise, Dr. Smith, in his usual happy way, rose to the occasion and again impressed upon his confreres the genuine pleasure he had taken in his past year's work and fired his listeners with new zeal for service that seeks the advancement of the public good. . . .

* * *

Los Angeles County: Los Angeles County Medical Association Meeting.—The regular scientific meeting of the Society took place December 2, 1920, at 8 p.m., in the Friday Morning Club House. . . .

* * *

Los Angeles County Hospital, December 1, 1920: Announcing the Opening of the Olive View Sanitarium for Tuberculosis.—This new institution, which is being operated as a ward of this hospital, is now receiving as patients those adults having definite tuberculosis who are ambulant and who are in the early stages of the

(Continued on Page 50)

"PREMARIN"
now available in
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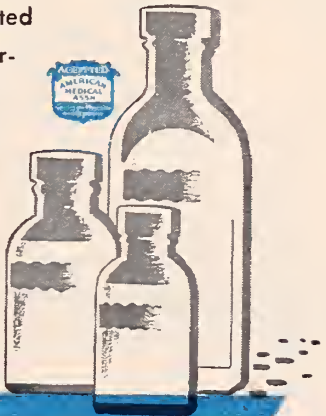
- To permit greater flexibility of dosage.
- To provide a graduated estrogenic intake where required.
- To accommodate those patients who are partial to liquid medication.
- "*Premarin*" Liquid . . . conjugated estrogens (equine) . . . naturally occurring . . . orally active . . . well tolerated . . . imparts a feeling of well-being. Each teaspoonful is the equivalent in potency of one "Premarin" Tablet (Half-Strength) No. 867.

Available in bottles of 120 cc. (4 fluid oz.), No. 869



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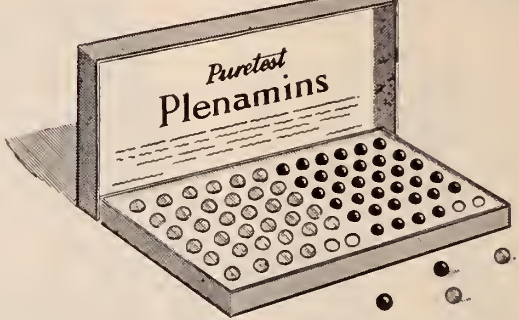

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TWENTY-FIVE YEARS AGO

(Continued from Page 48)

disease or who are in a condition that is considered favorable for early arrestment. It is expected that children will be admitted as soon as suitable accommodation can be provided. From the social standpoint its patients are those who are unable to pay for private sanitarium treatment and who are citizens of the United States and who have resided in Los Angeles County for one year immediately preceding application for admission. Advanced cases among indigents are cared for at this hospital as heretofore. . . .

The poorest way to face life is to face it with a sneer.
—Theodore Roosevelt, *Speech*, University of Paris.

Classified Advertisements

(Continued from Page 10)

WANTED: Complete office equipment including instruments, tables, scales, laboratory and X-ray equipment. Box 9600, California and Western Medicine.

Tuberculosis in Central Europe

The Nazi concentration camps created a grave source of dissemination of tuberculosis in Europe. Disease contracted there, and now in its incipiency, may be expected to develop for months or years after the general repatriation, which is now well under way. The recognition and control of tuberculosis in men returning from these concentration camps will be a problem for the health officers of every country whose nationals were imprisoned. U. S. Army Dept. Bulletin, October, 1945.

More pleasure to you, Doctor!

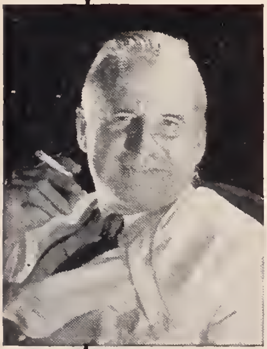
THREE nationally known research organizations recently reported the results of a nationwide survey to discover the cigarette preferences of physicians and surgeons.

Physicians all over the United States were asked the simple question: "What cigarette do you smoke, Doctor?" The question was put solely on the basis of *personal preference as a smoker.*

The thousands and thousands of answers from these physicians in every branch of medicine were checked and re-checked. The result:

> **More physicians named Camel as their favorite smoke than any other cigarette. And the margin for Camels was most convincing.**

Certainly the average physician is busier today than ever before and is deserving of every bit of relaxation he can find in his day-by-day routine . . . a cigarette now and then if he likes. And the makers of Camels are glad to know that physicians find in Camels that extra margin of smoking pleasure that has made Camels such a favorite everywhere.



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TURKISH & DOMESTIC BLEND CIGARETTES

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A comprehensive report published in *Human Fertility*[1] shows an overwhelming preference by experienced clinicians for the "Diaphragm and Jelly" method of conception control.

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On the evidence supplied by competent clinicians we continue to suggest that for the optimum in protection the physician should prescribe the combined use of a vaginal diaphragm and spermatocidal jelly.

When you specify "RAMSES"* a product of highest quality is assured.

Gynecological Division
JULIUS SCHMID, INC.
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[1] Human Fertility, 10:25, March, 1945.

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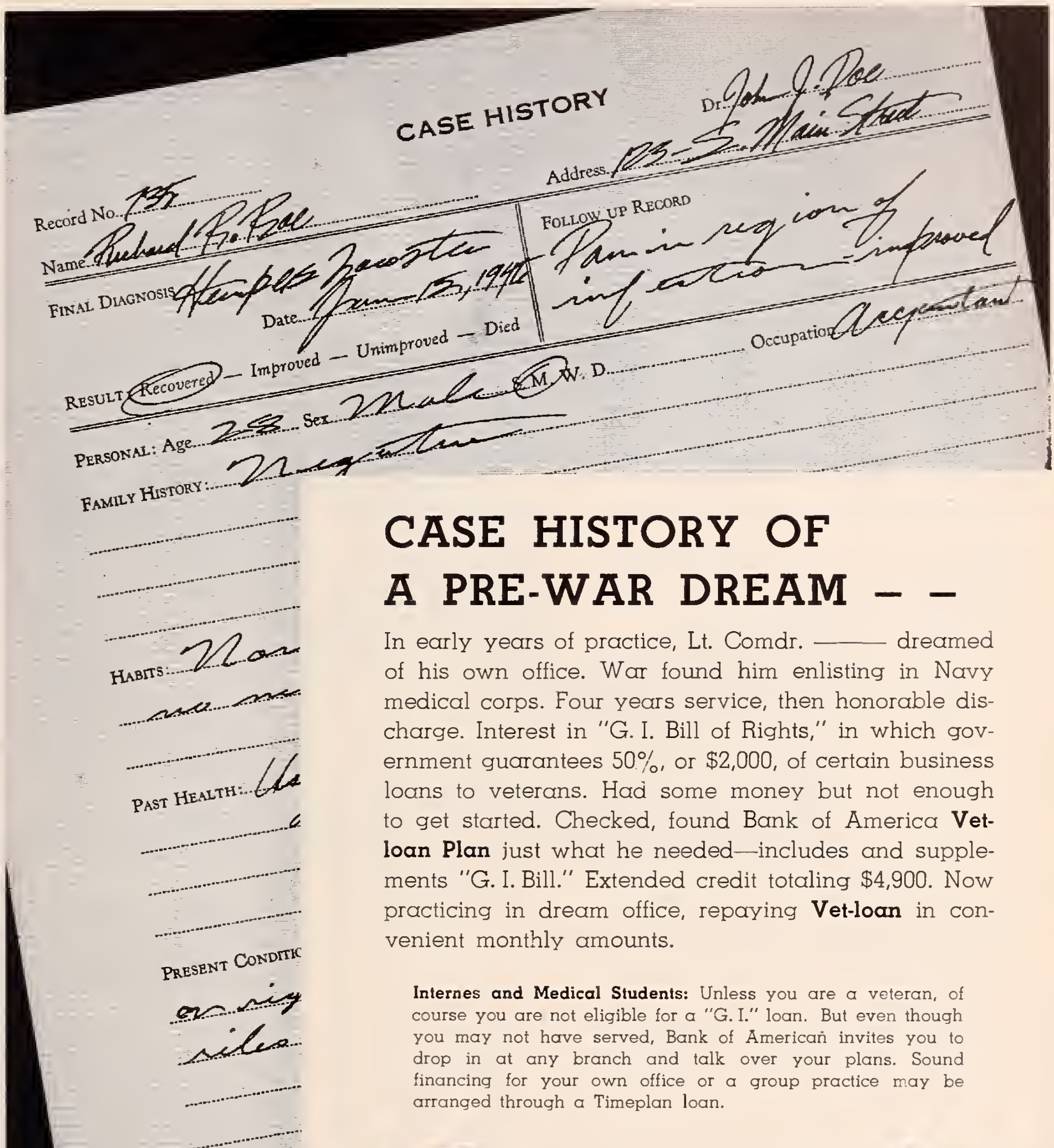


CASE HISTORY

Dr. John J. Doe

Address 123 S. Main Street

Record No. 137

Name Richard R. Roe

FINAL DIAGNOSIS

Date Jan 15, 1946

FOLLOW UP RECORD Pain in region of infection—improved

RESULT: [✓ Recovered] — Improved — Unimproved — Died

Occupation Accountant

PERSONAL: Age 23 Sex Male S. M. W. D.

FAMILY HISTORY: Negative

HABITS:

PAST HEALTH:

PRESENT CONDITI

PHYSICAL E

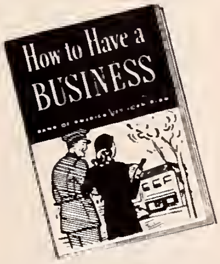
TEMP

HEAD: (i

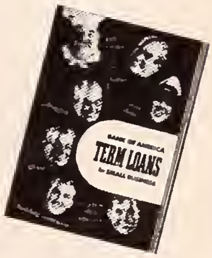
CASE HISTORY OF A PRE-WAR DREAM – –

In early years of practice, Lt. Comdr. ——— dreamed of his own office. War found him enlisting in Navy medical corps. Four years service, then honorable discharge. Interest in "G. I. Bill of Rights," in which government guarantees 50%, or $2,000, of certain business loans to veterans. Had some money but not enough to get started. Checked, found Bank of America **Vet-loan Plan** just what he needed—includes and supplements "G. I. Bill." Extended credit totaling $4,900. Now practicing in dream office, repaying **Vet-loan** in convenient monthly amounts.

Internes and Medical Students: Unless you are a veteran, of course you are not eligible for a "G. I." loan. But even though you may not have served, Bank of Americañ invites you to drop in at any branch and talk over your plans. Sound financing for your own office or a group practice may be arranged through a Timeplan loan.



"How to Have a Business" and "Term Loans for Small Business" are two helpful Bank of America booklets which you might like to read. They are yours for the asking at any branch.



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COLFAX, CALIFORNIA

Dr. Robert A. Peers, Medical Director of the Colfax School for the Tuberculous, wishes to announce the addition to the staff of Dr. Judith Dudley Smith as Associate Director. Dr. Smith is a graduate of the Woman's Medical College of Pennsylvania and interned at the Charity Hospital in New Orleans. She has been Resident Physician at the Colfax School for the Tuberculous since January 1, 1945.

* * *

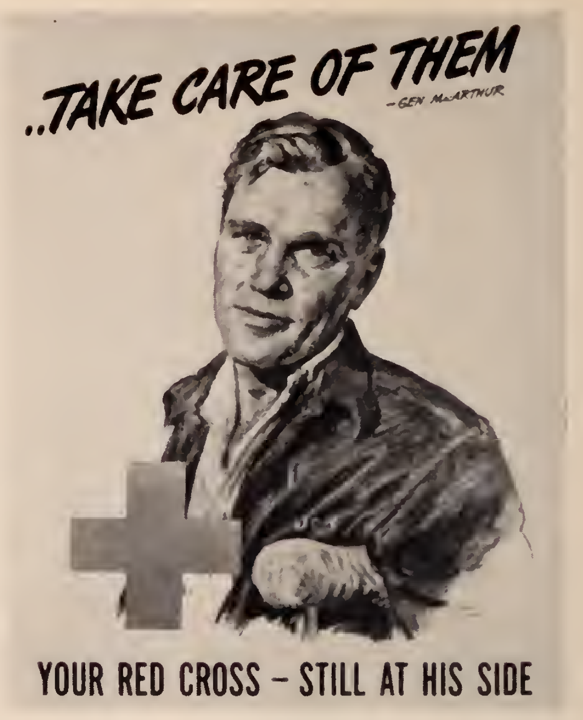
For further information
write
ROBERT A. PEERS, M.D.
Medical Director
COLFAX, CALIFORNIA

* * *

JUDITH DUDLEY SMITH, M. D.
Associate Medical Director

F. HARRY BENTEEN, M. D.
Consultant in General Surgery
(Stanford Hospital),

EMILE HOLMAN, M. D.
Consultant, Thoracic Surgery



S. F. Chapter, American Red Cross: 1946 Red Cross Fund

Red Cross was their friend through the years of war. And Red Cross still stands hand in hand with the wounded, the man overseas, the returned veteran and his family.

Its war job is only partly finished. And, in order to finish the task, Red Cross will ask San Francisco in March to contribute $1,547,000 as its share of the 1946 Red Cross fund.

Jean C. Witter, chairman of the successful 1945 drive, again is general campaign chairman for San Francisco and has as his aides most of the committee heads who assisted him last year. These leaders are eager to give their efforts because of their appreciation of the vital services performed by Red Cross and of the necessity of continuing them.

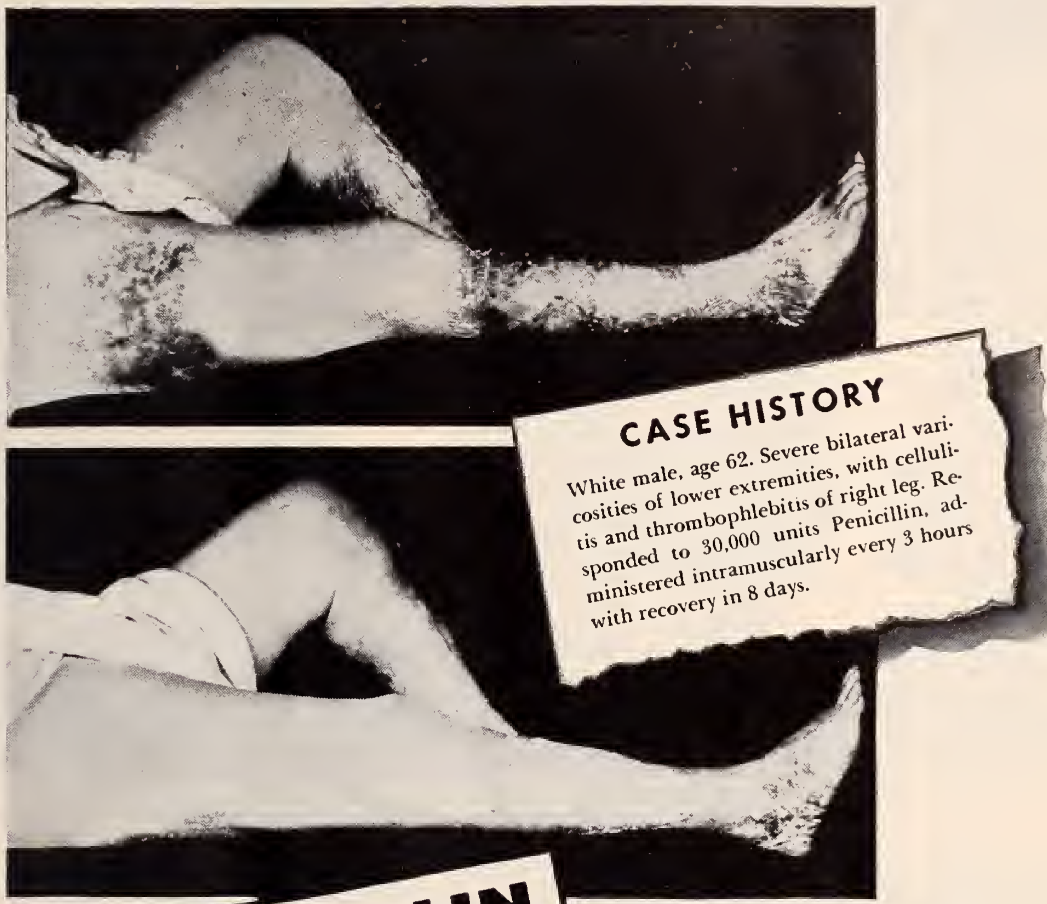
Several thousand Red Cross field workers remain on foreign duty and many will stay there until the last American soldier is brought home. In the military camps and hospitals in this country thousands of other workers wear the tiny red emblem that is a sort of magic symbol to those in pain. Tens of thousands of wounded are still in those hospitals—and will be there longer than you think. And Red Cross will stay there, too, with its arts and skills, its recreation and welfare programs, its Gray Ladies.

For the veteran with the snarled family problems, with financial troubles, Red Cross must provide guidance and help on the largest scale in the organization's history. The parades are over but not the veteran's problems.

At the same time Red Cross must assume peacetime obligations that should be curtailed no longer now that the war has ended. Disaster relief, home nursing, first aid—all vital community services—will be expanded to meet increased civilian needs.

Some idea of the task confronting Red Cross may be obtained any day at the docks where thousands of returning servicemen stream across the piers and are met, day and night, by the Red Cross volunteers. Since the first year of war, Red Cross canteen workers have

(Continued on Page 56)



CASE HISTORY

White male, age 62. Severe bilateral varicosities of lower extremities, with cellulitis and thrombophlebitis of right leg. Responded to 30,000 units Penicillin, administered intramuscularly every 3 hours with recovery in 8 days.

PENICILLIN in CELLULITIS

Serious local infections such as cellulitis due to hemolytic streptococcic infections—with or without bacteremia—respond rapidly and dramatically to Penicillin.

Initial dosage of 15,000 to 20,000 units is advised. Constant intravenous injection of an isotonic sodium chloride solution follows, allowing administration of 5,000 to 10,000 units every hour, or 120,000 to 240,000 units in a twenty-four hour period. If this method is found inadvisable, 20,000 to 40,000 units may be injected intramuscularly every three or four hours.*

Bristol Penicillin, because of its low toxicity and freedom from pyrogens, its absolute sterility and standard potency, provides dependable therapeutic action.

For additional current literature on the clinical uses of this potent antibiotic, refer to your issues of the **BRISTOL PENICILLIN DIGEST.**

*Keefer C. S. et al.: New Dosage Forms of Penicillin, J.A.M.A. 128: 1161 (Aug. 18) 1945.

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Medical Directors, Pasadena, California

S. F. Chapter, American Red Cross: 1946 Red Cross Fund

(Continued from Page 54)

seen off every transport, giving a parting wave and some small comfort to the men going out to fight. And today, Red Cross remains at the docks, serving as many as 30,000 of those same men a day as they return. Red Cross truly is San Francisco's hospitality committee. At Christmas when shiploads of high point veterans were tied up at the piers, stranded here, Red Cross set up emergency canteens and worked the clock around. For every returning soldier, for every wounded man there was a Christmas gift.

The war record of San Francisco Red Cross was really a testimonial to a city's heart. Foremost in home-front activities was the Blood Donor Service which produced over 700,000 pints of blood and plasma. No city in the country contributed so generously of its own self in relation to population as did San Francisco. In this city 10,000,000 surgical dressings were prepared by Red Cross volunteers. Its Motor Corps has driven two million miles on vital missions for the military, the blood service and those never-ceasing dock activities.

On the larger scale, American Red Cross proudly presents a magnificent national and world record:

Sixty million dollars in loans and grants to servicemen and their families since war began.

Almost nine million servicemen and their families assisted by various chapters.

Twenty-seven million prisoner of war packages produced in chapters throughout the nation.

More than 25,000,000 items sent to Army and Navy stations in the United States.

More than 50,000,000 persons in 41 countries given

(Continued on Page 58)

The Doctor *needs* a Champion

to listen to his troubles, counsel with him as he does with his patients, defend him to the last ditch, defeat unwarranted attacks upon him and save him from loss and worry through malpractice suits.

The Doctor *has* a Champion

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Trained Medical, Dental and Commercial Personnel
Nurses for Special Duty, Institutional and Home.

681 Market Street : San Francisco, 5
GArfield 4278
Marie Williams, Director

S. F. Chapter, American Red Cross: 1946 Red Cross Fund

(Continued from Page 56)

$150,000,000 in civilian war relief.

And this gigantic task of dispensing mercy goes on. One hundred million dollars is needed "to keep Red Cross at his side in 1946"—in the hospitals, in bases overseas, on the streets at home. Local Red Cross leaders are confident that San Francisco, as always, will do its share. Truly it is said that the war is never over for Red Cross.—San Francisco Chapter, American Red Cross, 600 Sutter Street.

BOOK REVIEWS

(Continued from Page 20)

Nitrous Oxide-Oxygen Anesthesia: McKesson-Clement Viewpoint and Technique By F. W. Clement, Major M.C. (A.U.S.); formerly director of Anesthesia at Flower Hospital, the State Hospital for the Insane, Lucas County Hospital, Toledo Dental Dispensary; Anesthetist to Toledo, Mercy and St. Vincent's Hospitals, Toledo, Ohio; Fellow of the International College of Anesthetists; Member of the International Anesthetic Research Society, Diplomat of the American Board of Anesthesiology, Member of the Postgraduate Association of Regional Anesthesia, New York; Past-President of the Midwestern Society of Anesthetists, 1932; Past-President of the Associated Anesthetists of the United States and Canada, 1938; Member of the Ohio Society of Anesthetists. Second edition, thoroughly revised, illustrated with 92 engravings. Cloth. Price, $4.50. Pp. 288. Philadelphia: Lea & Febiger, 1945.

In all fields of scientific endeavor, progress and change go hand in hand. The recent world-wide conflict has greatly accelerated research and investigation in every branch of science.

So far, there have been no radical changes in either the agents used for anesthesia or their methods of administration. However, those in present use are being tested under conditions which will either confirm or disprove their efficacy.

The fundamentals of nitrous oxide-oxygen anesthesia, however, have not changed. A thorough knowledge of such allied subjects as physiology, pharmacology and chemistry is essential for its intelligent administration; otherwise, the anesthetist becomes merely a technician performing his duties in an empirical manner. An intimate knowledge of the physiology of the respiratory and the cardio-vascular systems, including the close inter-relationship of hypoxia, carbon dioxide excess, and asphyxia, and the clinical significance of the chemo receptors of the carotid and aortic bodies, is imperative for the proper interpretation of the signs of anesthesia.

TOWARD A

MORE NORMAL CHILDHOOD

Natural and healthy childhood exuberance may be limited to anal pathology not demonstrable by anal stricture but nevertheless incapacitating and conducive to lethargy, nervousness and insomnia. Muscle tone greater than normal, especially in association with an atonic colon, is often reduced by mechanical dilation with YOUNG'S DILATORS.

More serious obstructions are sometimes eliminated by repeated dilatations, and normal anal function is resumed.

YOUNG'S DILATORS in children's small and intermediate sizes, sold on prescription only, are available in bakelite; boilable and easily inserted by parent or nurse. Postoperative use of YOUNG'S DILATORS after pediatric anal surgery to relieve stenosis and atresia of the anus and rectum is also recommended by pediatricians and proctologists. Children's set of 4 sizes $4.50. Adult set of 4 sizes $4.75. Available at ethical drug stores or your surgical supply house. Literature sent on request.

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Most physicians deplore the advent of pregnancy in the presence of a serious underlying psychic imbalance or defect—or in many cases of readily transmissible conditions such as schizophrenia and epilepsy. • In multiple sclerosis, childbearing often leads to an aggravation of symptoms, while in many neuroses or psychoses it may produce serious mental deterioration. • Ortho-Gynol Vaginal Jelly, accepted by the American Medical Association Council on Pharmacy and Chemistry, is well adapted for prescription whenever conception may be judged inadvisable in such instances. It is promptly spermicidal, non-irritant on protracted use, and easy to apply.

ALSO AVAILABLE AS ORTHO-CREME

Ortho-Gynol
VAGINAL JELLY

ACTIVE INGREDIENTS:
ricinoleic acid, 0.7%, boric acid, 3.0%, oxyquinoline sulfate, 0.025%.

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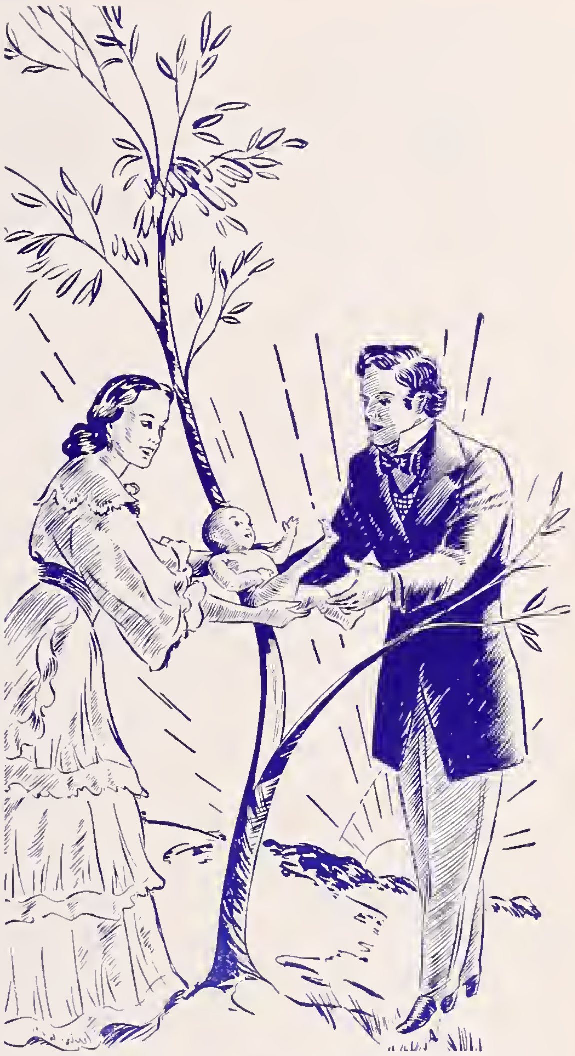
Old Way . . .

CURING RICKETS in the CLEFT of an ASH TREE

FOR many centuries,—and apparently down to the present time, even in this country—ricketic children have been passed through a cleft ash tree to cure them of their rickets, and thenceforth a sympathetic relationship was supposed to exist between them and the tree.

Frazer* states that the ordinary mode of effecting the cure is to split a young ash sapling longitudinally for a few feet and pass the child, naked, either three times or three times three through the fissure at sunrise. In the West of England, it is said the passage must be "against the sun." As soon as the ceremony is performed, the tree is bound tightly up and the fissure plastered over with mud or clay. The belief is that just as the cleft in the tree will be healed, so the child's body will be healed, but that if the rift in the tree remains open, the deformity in the child will remain, too, and if the tree were to die, the death of the child would surely follow.



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

---

*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923

New Way . . .

Preventing and Curing Rickets *with* OLEUM PERCOMORPHUM

NOWADAYS, the physician has at his command, Mead's Oleum Percomorphum, a Council-Accepted vitamin D product which actually prevents and cures rickets, when given in proper dosage.

Like other specifics for other diseases, larger dosage may be required for extreme cases. It is safe to say that when used in the indicated dosage, Mead's Oleum Percomorphum is a specific in almost all cases of rickets, regardless of degree and duration. Mead's Oleum Percomorphum because of its high vitamins A and D content is also useful in deficiency conditions such as tetany, osteomalacia and xerophthalmia.

* * *

COUNCIL-ACCEPTED

Oleum Percomorphum With Other Fish-Liver Oils and Viosterol. Contains 60,000 vitamin A units and 8,500 vitamin D units per gram and is supplied in 10 c.c. and 50 c.c. bottles; and in bottles containing 50 and 250 capsules.

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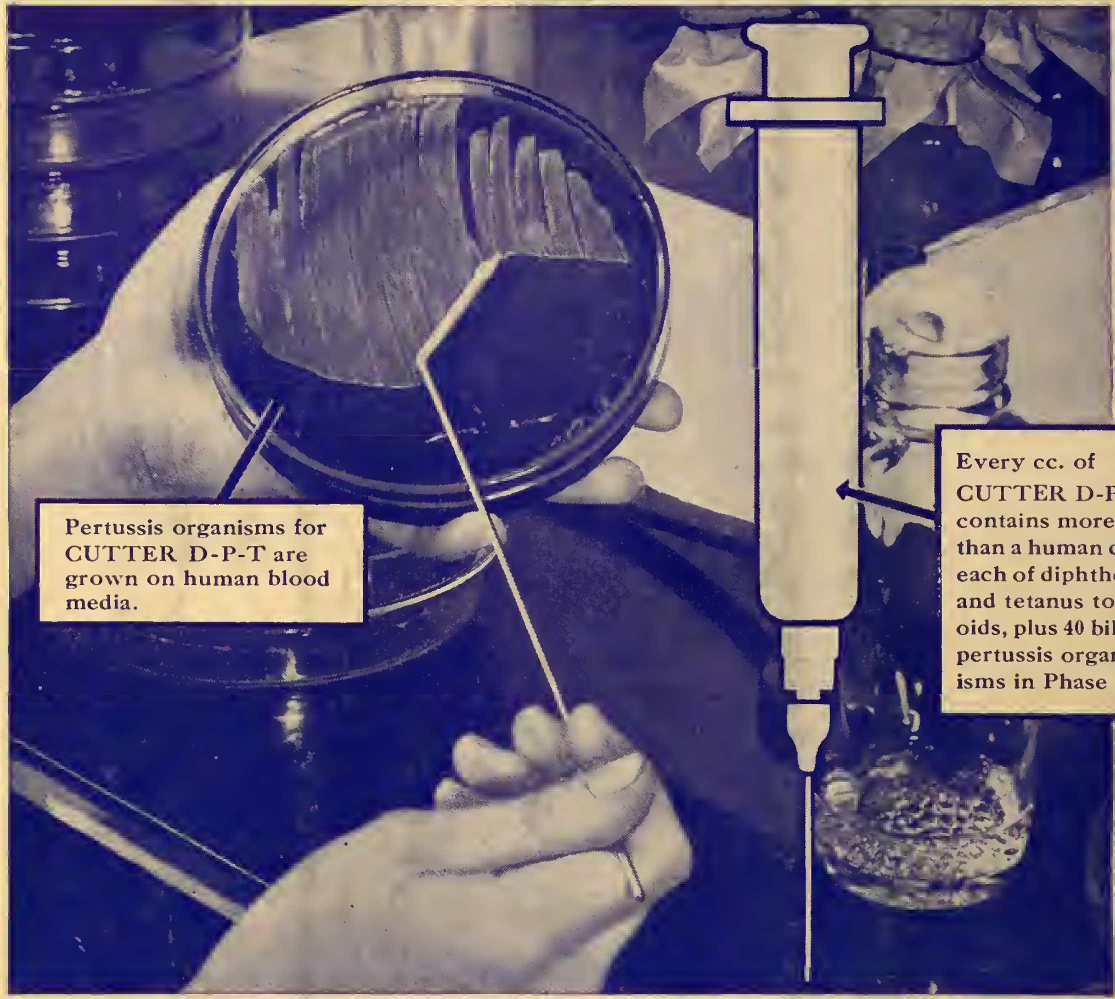
Please enclose professional card when requesting samples of Mead Johnson products to co-operate in preventing their reaching unauthorized persons



Pertussis organisms for CUTTER D-P-T are grown on human blood media.

Every cc. of CUTTER D-P-T contains more than a human dose each of diphtheria and tetanus toxoids, plus 40 billion pertussis organisms in Phase I.

WHICH combined vaccine will you use on your patients?

The following may be helpful in finding a satisfactory answer:

It has been established by most investigators that 100 billion organisms in Phase I is the optimum pertussis dosage for children under three. *Pertussis organisms for Cutter D-P-T, grown on human blood media, are guaranteed to be in Phase I, with 40 billion organisms per cc.*

While adequate protection must be provided against all three diseases, injections must not be so large as to cause undue pain and tissue distention. *Purified toxoids and extremely high pertussis count yield a vaccine so concentrated that your dosage schedule with D-P-T is only 0.5 cc., 1 cc., 1 cc.*

Sterile abscesses, often a danger when pertussis vaccine is mixed with alum toxoids, are to be avoided. *Cutter D-P-T (Alhydrox) is aluminum hydroxide adsorbed, determined by Miller to be more potent than alum precipitated vaccines. Moreover, persistent nodules and sterile abscesses are eliminated almost entirely, and there is less pain on injection because of a more normal pH.*

May we suggest that you use Cutter D-P-T in your practice, observing its many advantages to your own satisfaction? Cutter Laboratories, Berkeley, California; Chicago, New York.

Leading pediatricians specify
CUTTER D-P-T

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American Medical Association, San Francisco, July 1-5, 1946.

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FOUR FIFTY SUTTER, ROOM 2004, SAN FRANCISCO

VOLUME 64
NUMBER 3

MARCH, 1946

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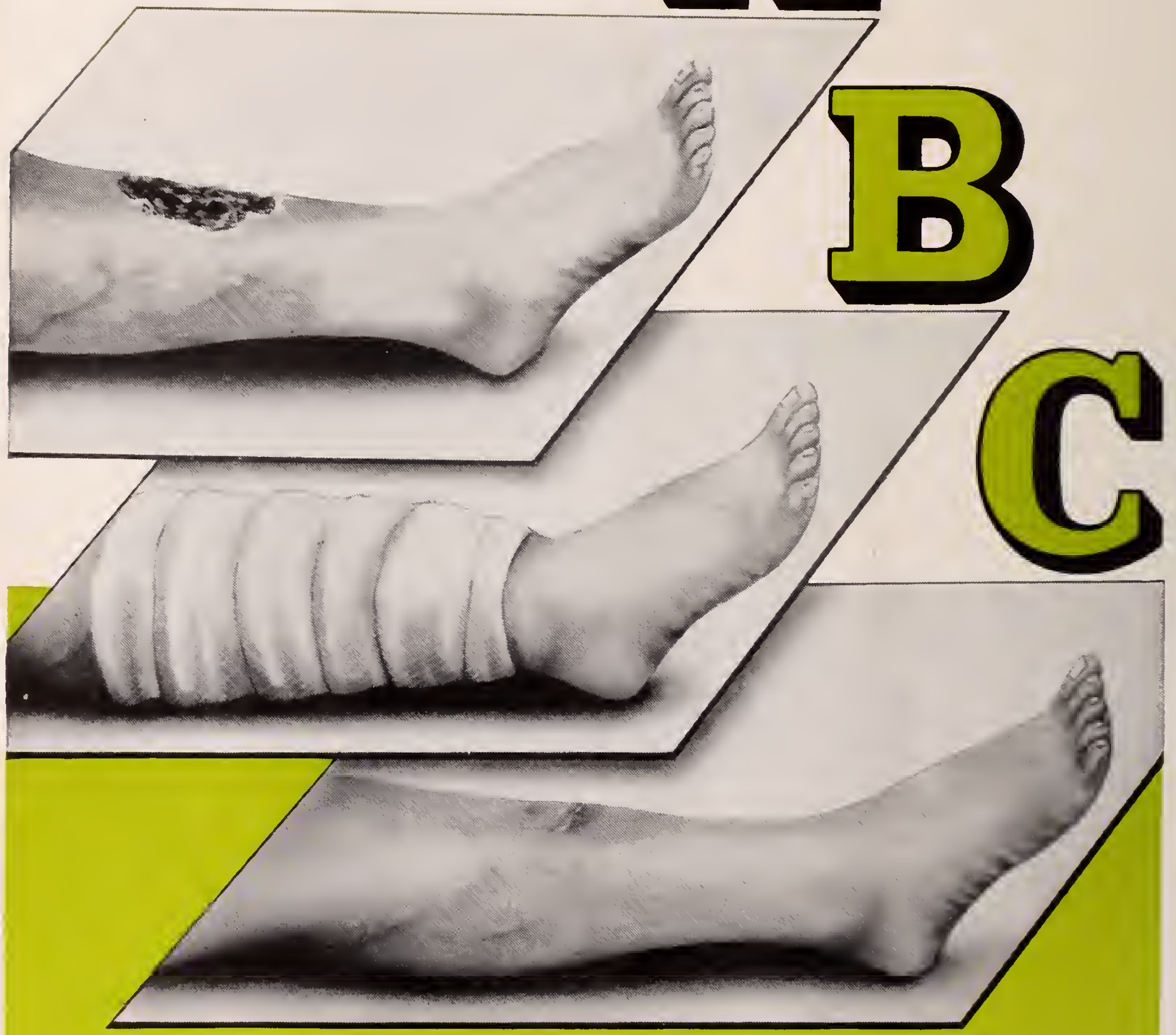

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TYROTHRICIN
2%
Each cc. contains 20 milligrams of Tyrothricin (A combination of Gramicidin and Tyrocidine).
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of superficial indolent ulcers and other skin lesions with TYROTHRICIN . . . a most important antibiotic agent.

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used in wet packs or by irrigation, is effective against streptococcic, staphylococcic and pneumococcic infections of superficial tissues, deeper tissues made accessible by surgical procedures, and body cavities in which there is no direct communication with the blood stream.

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Vice-Chairman—John W. Cline, 490 Post Street, San Francisco, 2.

Secretary-Editor—George H. Kress, 450 Sutter Street, Room 2004, San Francisco, 8.

Executive Secretary — John Hunton, 450 Sutter Street, Room 2004, San Francisco, 8.

General Counsel—Hartley F. Peart, Room 1800, 111 Sutter Street, San Francisco 4.

Councilors

In addition to the elected district and at-large Councilors, the Council has as ex-offico members the following general officers. President; President-Elect; Speaker: and the Association Secretary.
Council Officers: Philip K. Gilman, Chairman; George H. Kress, Secretary.

District Councilors

First District—Imperial, Orange, Riverside, San Bernardino and San Diego Counties, Herbert A. Johnston (1947), 117 N. Claudina Street, Anaheim.

Second District—Los Angeles County, Jay J. Crane (1948), 1921 Wilshire Boulevard, Los Angeles.

Third District—Inyo, Kern, Mono, San Luis Obispo, Santa Barbara and Ventura Counties, Harry E. Henderson (1946), 1421 State Street, Santa Barbara.

Fourth District—Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties, Axcel E. Anderson (1947), Medical Group Building, 1759 Fulton Street, Fresno.

Fifth District—Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz Counties, R. Stanley Kneeshaw (1948), 404 Medico-Dental Building, 241 East Santa Clara Street, San Jose.

Sixth District—San Francisco County, John W. Cline (1946), 1020 Medico-Dental Building, 490 Post St., San Francisco 2.

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Eighth District—Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties, Frank A. MacDonald (1948), 822 Medico-Dental Building, 1127 Eleventh Street, Sacramento 14.

Ninth District—Del Norte, Humboldt, Lake Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma and Trinity Counties, John W. Green (1946), Box 539, Vallejo.

Councilors-at-Large

Walter S. Cherry (1948), 109 N. Riverside Ave., Rialto, San Bernardino County.

Edwin L. Bruck (1948), 384 Post Street, San Francisco, 8.

Sidney J. Shipman (1947), 490 Post Street, San Francisco 2.

E. Earl Moody (1947), 829 South Alvarado Street, Los Angeles.

Dewey R. Powell (1946), Room 501, 242 North Sutter Street, Stockton 2.

Edward B. Dewey (1946), Professional Building, 65 North Madison Avenue, Pasadena.

Standing Committees

Executive Committee

The President, the President-Elect, the Speaker of the House of Delegates, the Chairman of the Council, the Chairman of the Auditing Committee, the Secretary-Treasurer (ex officio), and the Editor (ex officio). John W. Cline, Chairman; George H. Kress, Secretary.

Auditing Committee*

John W. Cline (Chairman)	San Francisco	1945
Edwin L. Bruck	San Francisco	1945
Lloyd E. Kindall	Oakland	1945

Committee on Associated Societies and Technical Groups

John V. Barrow (Chairman)	Los Angeles	1946
Anthony B. Diepenbrock	San Francisco	1947
Edward F. Nippert	Hollywood	1948

Committee on Health and Public Instruction

J. C. Geiger (Chairman)	San Francisco	1946
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C. M. Burchfiel	San Jose	1948

Committee on History and Obituaries

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Donald Cass (Chairman)	Los Angeles	1948

Committee on Medical Defense

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Nelson J. Howard (Chairman)	San Francisco	1947
William A. Key	San Mateo	1948

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Wayne J. Pollock	Sacramento	1947
H. Gordon MacLean (Chairman)	Oakland	1948

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L. R. Chandler	San Francisco	1948

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H. F. Freidell	Santa Barbara	1947
John C. Ruddock	San Diego	1948
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F. Burton Jones	Vallejo	1947
R. H. Sundberg	San Diego	1948
Secretary-Editor, ex officio		

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Dwight H. Murray (Chairman)	Napa	1947
Lloyd E. Kindall	Oakland	1948
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Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2004, 450 Sutter Street, San Francisco.

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* Members appointed each year by the Chairman of the Council.

OFFICERS OF SCIENTIFIC SECTIONS, CALIFORNIA MEDICAL ASSOCIATION

Members who contemplate presentation of scientific papers should promptly address the secretary of the proper section, as per addresses which follow. Correspondence concerning scientific exhibits, and medical and surgical films, should be addressed to the Chairman of the Committee on Scientific Work: George H. Kress, M. D., 450 Sutter, San Francisco.

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Chairman, Charles J. Betlach, 3326 Calle Noguerra, Santa Barbara.

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Chairman, William P. Kroger, 1930 Wilshire Boulevard, Los Angeles.

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C.M.A. Committee on Scientific Work: For membership of State Association Committee, see roster on page 2, or address: Dr. George H. Kress, Chairman, 450 Sutter, San Francisco (8), Calif.

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Headquarters office of the California Physicians' Service is located at 153 Kearny St., San Francisco, Postal Zone 8, Telephone EXbrook 0161. Los Angeles office located at 743 South Grand View St., Postal Zone 5, Telephone DRexel 5261.

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(Continued on Page 5)

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(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
364 14th Street, Oakland 12
President, Warren B. Allen, 411 30th Street, Oakland 9.
Secretary, Dorothy M. Allen, 2923 Webster Street, Oakland 9.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, Hollis L. Carey, 567 Kentucky Street, Gridley.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, George Kelso, 416 E. Fourth Street, Pittsburg.
Secretary, H. D. Neufeld, Box 338, Concord.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, J. A. Thormann, Box 1908, Fresno.
Secretary, William L. Adams, Jr., 515 Helm Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Walter Dolfini, 539 G Street, Eureka.
Secretary, Wayne P. McKee, Ferndale.
Meeting, *First Thursday.*

Imperial County Medical Society
President, T. E. Bartholomew, 319 Third Street, Calexico.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, Walter L. Wilson, 108 N. Main, Bishop.
Secretary, Lloyd S. Bambauer, Bishop.
Meeting, *Fourth Wednesday, except December, January, February.*

Kern County Medical Society
President, Sophie L. Goldman, 458 Haberfelde Building, Bakersfield.
Secretary, Frederick O. Wynia, 354 Haberfelde Building Bakersfield.
Meeting, *Third Tuesday, 7:30 p.m., Stockdale Country Club, except June, July, August.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, William F. Chamlee, Van Sicklen Building, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, Fred J. Davis, Jr., 920 Pine Street, Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles 5
President, Louis J. Regan, 6777 Hollywood Boulevard, Los Angeles 28.
Secretary, E. T. Remmen, 429 North Orange, Glendale 3.
Meeting, *First and Third Thursday, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Lloyd G. Tyler, 1010 B Street, San Rafael.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 7:00 p.m., Travelers Inn, San Rafael.*

Mendocino-Lake County Medical Society
President, J. E. Gardner, 215 W. Standley Street, Ukiah.
Secretary, E. C. Bennett, Ukiah.

Merced County Medical Society
President, E. R. Fountain, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Margaret Swigert, Professional Building, Monterey.
Secretary, Sebastian Carnazzo, 411 Alvarado Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, Charles H. Bulson, 1203 Seminary Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, John Montanus, Rt. 1, Box 587A, Santa Ana.
Secretary, Russell I. Johnson, 181 Westminster Boulevard, Westminster.
Meeting, *First Tuesday, 7:00 p. m., Windsor Cafe, Santa Ana.*

Placer-Nevada-Sierra County Medical Society
President, George A. Foster, Grass Valley.
Secretary, Vernon W. Padgett, Grass Valley.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Franklyn D. Hankins, 3014 Pine Street, Riverside.
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Frank Reardon, Physicians Building, Sacramento
Secretary, Edmund E. Simpson, 1127 Eleventh Street, Sacramento 14.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, J. J. Haruff, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Carl M. Hadley, 315 Platt Building, San Bernardino.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
President, A. E. Moore, 2120 Fourth Avenue, San Diego 1.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego, 1.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2190 Washington Street 9
President, Chester L. Cooley, 490 Post Street, San Francisco 2.
Secretary, Robertson Ward, 2180 Washington Street, San Francisco 9.
Meeting, *Second Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco, 9.*

San Joaquin County Medical Society
President, Dora Ames Lee, 110 North San Joaquin Street, Stockton 6.
Secretary, H. D. Chope, Box 111, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Edward C. Sherman, 784 Marsh Street, San Luis Obispo.
Secretary, G. D. Kelker, 1114 Marsh Street, San Luis Obispo.
Meeting, *Fourth Wednesday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, A. G. Miller, 205 Third Avenue, San Mateo.
Secretary, J. Paul Sweeney, 1149 Rosewood Avenue, San Carlos.
Meeting, *At call of President.*

Santa Barbara County Medical Society
President, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Secretary, Charles A. Preuss, 1317 Santa Barbara Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, Charles A. Fernish, 226 Sainte Clare Building, San Jose 23.
Secretary, Fred W. Borden, Sainte Claire Building, San Jose, 23.

Santa Cruz County Medical Society
President, Ruth A. Frary, 123 East Third Street, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

Shasta-Trinity County Medical Society
President, L. C. Mosher, Bieber.
Secretary, Julius M. Kehoe, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, Richard W. Jones, 106 South Broadway, Yreka.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, John W. Green, Box 539, Vallejo.
Secretary, Clark T. Alexander, 731 Sonoma Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.*

Sonoma County Medical Society
President, William Stegeman, 534 B Street, Santa Rosa.
Secretary, Raimond F. Clary, 1616 Fourth Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, J. Lyle Spellman, P. O. Box 1412, Modesto.
Secretary, Richard R. Treadwell, P. O. Box 801, Modesto.
Meeting, *Second Friday, 7:30 p.m., Hotel Hughson.*

Tehama County Medical Society
President, James L. Faulkner, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, George Keiper, Bank of America Building, Visalia.
Secretary, Irvin H. Betts, 222 West Willow Street, Visalia.

Ventura County Medical Society
President, A. W. Cruden, Saticoy.
Secretary, George H. Arnold, Route 2, Box 12, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Charles S. Roller, 604 Woodland Avenue, Woodland.
Secretary, Emery Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, Leon M. Swift, Box 244, Marysville.
Secretary, D. Ermorine Edwards, 725 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

(For roster of C.M.A. committees and other organization, see last month's issue.)

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(Continued from Page 3)

Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 364 Fourteenth Street, Oakland, 12. (Phone HIgate 7600.) 153 Kearny Street, San Francisco, 8. (Phone GArfield 0813.) 67 East Santa Clara, San Jose.

Hospital Service of Southern California, 743 South Grand View Street, Los Angeles. (Phone DRexel 5261.)

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento. (Main 2548.)

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WEst 8000, Extension 75.

Barlow Medical Library (Los Angeles County Medical Association), 634 So. Westlake, Los Angeles 5. Phone FItzroy 7694.

Note.—The Library of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, also maintains a medical literature packet service.

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BOOK REVIEWS

BOOKS RECEIVED

The Care of the Aged (Geriatrics). By Malford W. Thewlis, M.D., Attending Specialist, General Medicine, United States Public Health Hospitals, New York City; Attending Physician, South County Hospital, Wakefield, R. I.; Director, Thewlis Clinic; Special Consultant, Rhode Island Department of Public Health. Fifth editon, thoroughly revised. Cloth. Pp. 500, with 65 illustrations. St. Louis: The C. V. Mosby Company, 1946.

The 1945 Year Book of Industrial and Orthopedic Surgery. Edited by Charles F. Painter, M.D., Orthopedic Surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. Cloth. Price, $3.00. Pp. 432, illustrated. Chicago: The Year Book Publishers, 1946.

Gelatin in Nutrition and Medicine. By N. R. Gotthoffer, Director of Research, Grayslake Gelatin Company, Grayslake, Illinois. Grayslake, Illinois: Grayslake Gelatin Company, 1945.

The Physiological Basis of Medical Practice. A University of Toronto Text in Applied Physiology by Charles Herbert Best, C.B.E., M.A., M.D., D.Sc. (Lond.), F.R.S., F.R.C.P. (Canada), Professor and Head of Department of Physiology, Director of the Banting-Best Department of Medical Research, University of Toronto, and Norman Burke Taylor, V.D., M.D., F.R.S. (Canada), F.R.C.S. (Edin.), F.R.C.P. (Canada), M.R.C.S. (Eng.), L.R.C.P. (Lond.), Professor of Physiology, University of Toronto. Fourth edition. Cloth. Price, $10.00. Pp. 1169, illustrated. Baltimore: The Williams and Wilkins Company, 1945.

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Impaired liver function and bile flow—so pronounced after biliary tract surgery—call for the speediest possible restoration. At this crucial period of hepatobiliary depression, the usual stimulant influence of certain commonly eaten foods on bile production and evacuation cannot be invoked at an adequately early point in the postoperative period.

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Decholin sodium is supplied in 20 per cent solution, in boxes of three and twenty 3 cc., 5 cc., and 10 cc. size ampules. Decholin 3¾ grs. is available in boxes of 25, 100 and 500 tablets.

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SPECIALISTS are invited to apply for the few remaining suite in a new Berkeley Medical Building. The details and a sketch of the structure appears on page 20 of this issue. S. H. Babington, M.D., 2301 Ward Street, Berkeley 5, California.

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PHYSICIANS WANTED—California Licensed. Pathologist, certified to head laboratories; Radiologist to associate, General Man, young, associate two established men; EENT man to take over practice; Associate wanted capable of surgery and obstetrics. Pacific Coast Medical Bureau, 334 Mills Building, San Francisco 4, California.

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AZNOE'S, established 1896, has available a splendid group of well trained Physicians for appointments. Many desire assistantships; others are specialists qualified to head departments. We also place Nurses, Dietitians, Laboratory, X-ray and Physiotherapy Technicians. For biographies, please write Ann Woodward, Director, Aznoe's - Woodward Medical Personnel Bureau, 30 North Michigan, Chicago 2.

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—Alfred J. Talley, *Interview, on returning from Europe.*

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Plastic Pocket-Size Set (No. 2106) Includes all essentials for testing.

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In malnutrition, convalescence, anorexia and old age, more than vitamins are often indicated. Besides vitamins there are maltose, dextrose and dextrins and other food elements present in Maltine with Vitamin Concentrates.

Some of the food elements in Maltine with Vitamin Concentrates— approximate content per 30 cc. (2 tablespoonfuls).

VITAMIN A	**10,000 U.S.P. units**
VITAMIN D	**1,000 U.S.P. units**
THIAMINE HYDROCHLORIDE	**3 mg.**
RIBOFLAVIN	**4 mg.**
NICOTINAMIDE	**40 mg.**
+MALTOSE	**9.6 gm.**
+DEXTROSE	**4.2 gm.**
+DEXTRINS	**10.2 gm.**
+PHOSPHORUS	**279 mg.**
+CALCIUM	**303 mg.**
+CHOLINE*	**36 mg.**
+INOSITOL*	**44 mg.**
+FOLIC ACID*	**22 mcg.**

**These constituents are members of the natural B Complex. Their need in human nutrition has not been established.*

Two tablespoonfuls supply at least twice the minimum daily requirements of the above vitamins and supplementation of other easily digested food elements. The Maltine Company, New York 22.

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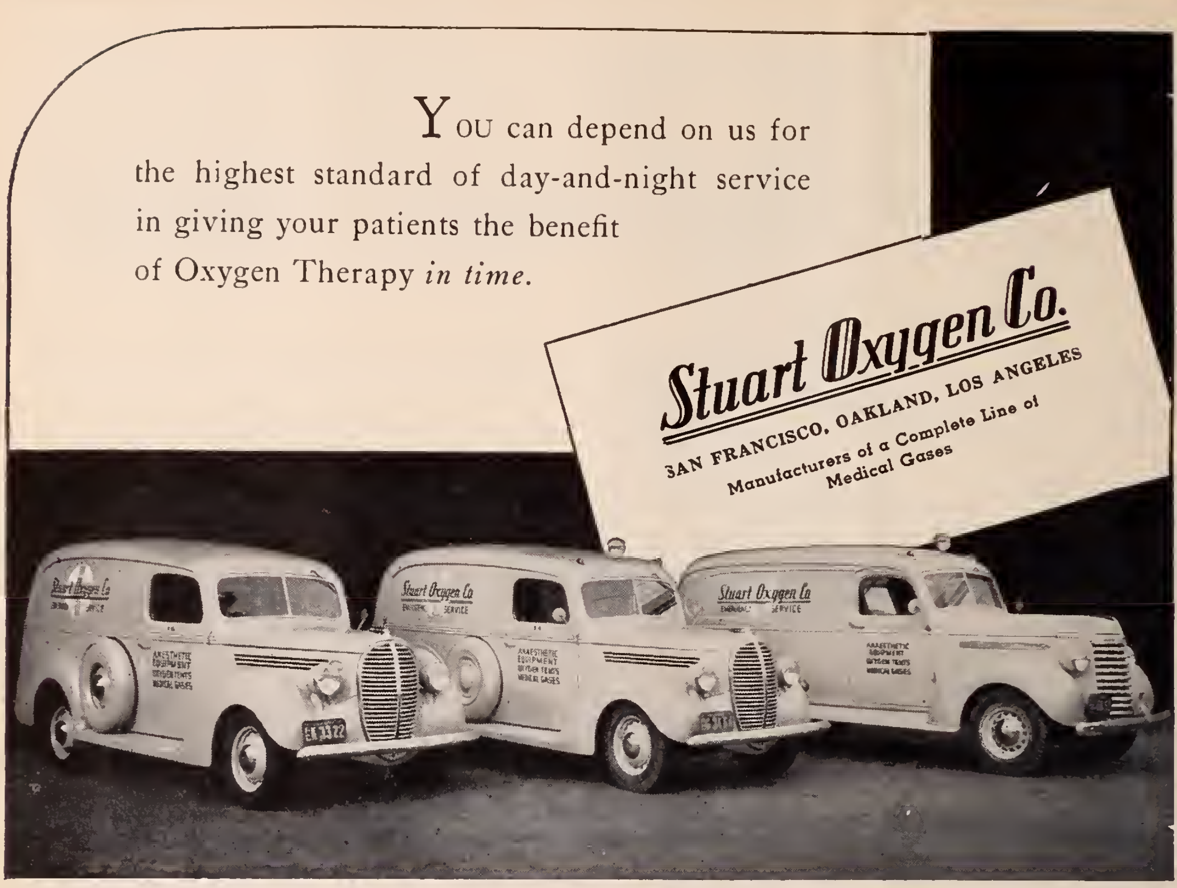
. . . MORE THAN A CAPSULE COULD HOLD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SAN FRANCISCO.

TWENTY-FIVE YEARS AGO

(Continued from Page 164)

tuberculosis associations no longer needs comment. The present situation in San Francisco merits extended notice both as an example and as a stimulant to other communities. . . .

The Tuberculosis Association opened its first clinic in 1908. During the year 346 patients visited the clinic. Two physicians and two nurses were in attendance. From that time until the present the work has steadily increased, more and more people each year learning the value of expert examination and advice. . . .

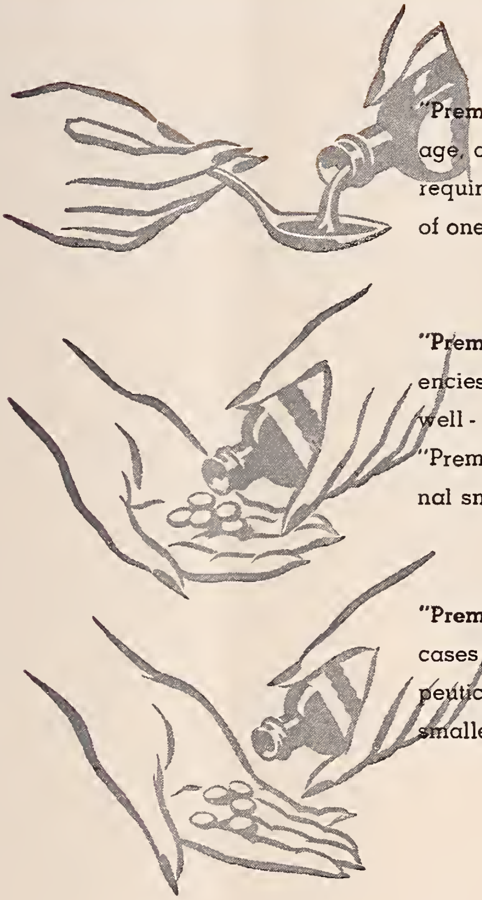
A Battleship for Public Health.—A strange spectacle, indeed, to see all those nations which did not bankrupt themselves in the great war, now belaboring themselves with insane fury in the ardor of building and equipping and maintaining huge military armaments. Seldom have great social reforms been accomplished because they were morally right. Still less often have reforms in society or medicine been made effective because they contributed to health, happiness or goodness. . . .

Instead of frenzied taxing for a huge armament, let us have a reasonable attention on the part of our law-makers to the demands, and rights, and dividends of money invested in national health. Let us convert a battleship of steel and destruction, into a mighty engine of life and human construction.

Epidemic Smallpox.—The morbidity of smallpox has

(Continued on Page 16)

FITTING ESTROGENIC THERAPY TO THE CASE



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Highly Potent • Orally Active • Water Soluble • Naturally Occurring • Essentially Safe • Well Tolerated • Imparts a Feeling of Well-Being.

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Reg. U. S. Pat. Off.

CONJUGATED ESTROGENS
(equine)

AYERST, McKENNA & HARRISON LIMITED • 22 East 40th Street, New York 16, N. Y.

prescribe this sedative with assurance
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. . . that your patients will be provided with a night's refreshing sleep, in the majority of instances, with relative freedom from unpleasant side-effects of excitation or "hangover." 'Delvinal' sodium vinbarbital is a mild sedative that provides a relatively brief induction period and a moderate duration of action. It is Council-accepted. Indicated for the relief of functional insomnia, for general sedation, preanesthetic hypnosis, psychiatric sedation, obstetric amnesia, and in pediatrics. Supplied in ½ gr., 1½ gr. and 3 gr. capsules. Sharp & Dohme, Philadelphia 1, Pa.

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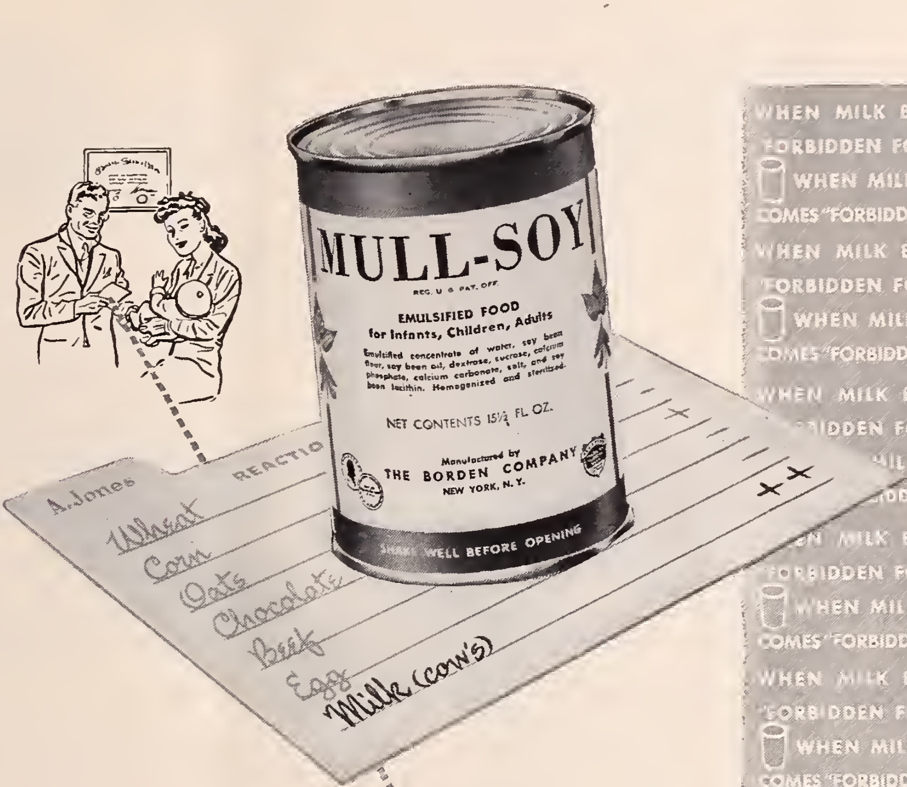
SODIUM VINBARBITAL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REG. U.S. PAT. OFF.
EMULSIFIED FOOD
for Infants, Children, Adults
Emulsified concentrate of water, soy bean flour, soy bean oil, dextrose, sucrose, calcium phosphate, calcium carbonate, salt, and soy bean lecithin. Homogenized and sterilized.
NET CONTENTS 15½ FL. OZ.
Manufactured by
THE BORDEN COMPANY
NEW YORK, N.Y.
SHAKE WELL BEFORE OPENING
A. Jones
REACTIO
Wheat
Corn
Oats
Chocolate
Beef
Egg
Milk (cow's)
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WHEN MILK BECOMES "FORBIDDEN FOOD"

Bridge the "nutritional gap"

The nutritional benefits of milk need not be deprived the "milk-sensitive" patient, even though successful treatment demands complete elimination of the offending food from the diet.

Clinical evidence has established MULL-SOY as an effective hypoallergenic substitute for cow's milk. This concentrated, emulsified soy bean food—homogenized and sterilized—closely approximates cow's milk in protein, fat, carbohydrate and mineral content. It is palatable, well tolerated, easy to digest and easy to prepare. Infants (particularly) thrive on MULL-SOY, and take it readily.

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For Intramuscular or Intravenous Use
A highly concentrated B-Complex
Each cc. contains Thiamin Hydrochloride, 5 mgs; Nicotinamide, 100 mgs; Calcium Pantothenate, 10 mgs; Riboflavin, 2 mgs; Pyridoxine, 10 mgs.
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WHEN OTHER MODALITIES FAIL
YOUNG'S Rectal Dilators
*Treatment of CONSTIPATION by dilation usually proves effective when habit forming laxatives and cathartics have proved inadequate or not tolerated. Set of 4 graduated bakelite dilators, adult $4.75, children's size $4.50. Obtain at your pharmacy or surgical supply dealer. Write for brochure. Sold on prescription only.
F. E. YOUNG & CO. 432 E 75th Street, Chicago 19, Ill.

TWENTY-FIVE YEARS AGO

(Continued from Page 12)

been increasing each year for the last four years until this year it is reaching alarming proportions, due no doubt to the large unvaccinated population growing up around us. Osler used to say that "the incidence of typhoid in a community reflects the sanitary intelligence of that community." This maxim could be even more aptly applied to smallpox, for in this disease we have an absolute means of prevention. Smallpox is excessively rare in an individual who has been successfully vaccinated as recently as within twelve years. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Success: As Applied to Urology," by E. Spence De Puy, M.D., Oakland.—If to get what one wants is to be successful, then every one desires success, and as success in anything is dependent upon an application of the same inflexible laws, an apprehension of these laws is therefore desirable. . . .

The first law of success is that one must know what he wants. A test of whether one really wants to do a thing is whether he enjoys doing it. Primarily, then, does one want to be a urologist? . . .

As a second law it follows that *one must want what he wants.*

(Continued on Page 24)

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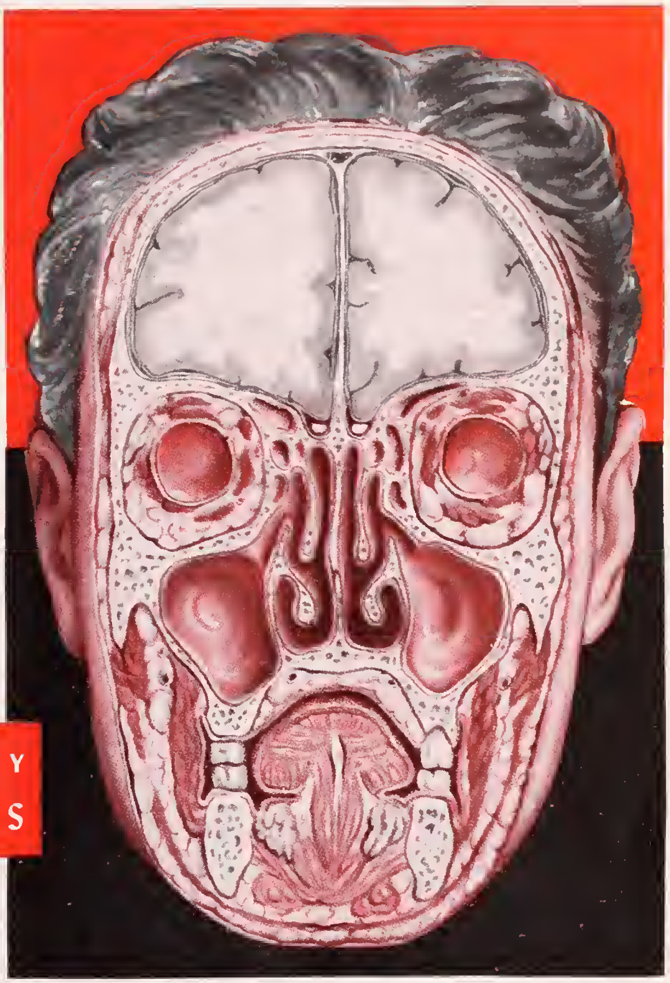

UPPER RESPIRATORY
INFECTIONS

IMPROVED RESULTS WITH **PRIVINE**
HYDROCHLORIDE

Widely prescribed during seasons of high incidence of upper respiratory infections, Privine has become a vasoconstrictor of choice. Physicians who employ Privine should remember that this solution of naphazoline hydrochloride is more potent than other vasoconstrictors now in use . . . For best results in using this product of wide benefit and high potency, it is suggested that the physician use extra care in giving his patient specific instructions as to the amount and duration of dosage.

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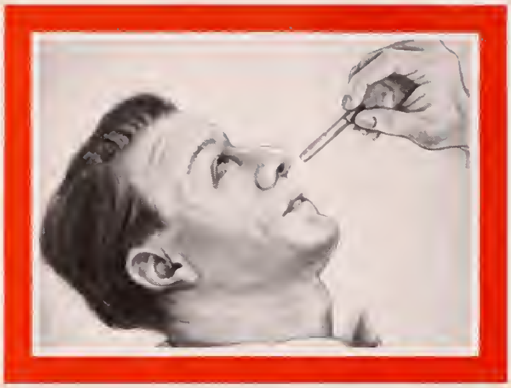
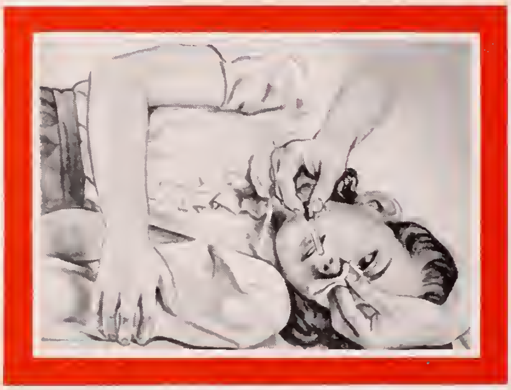
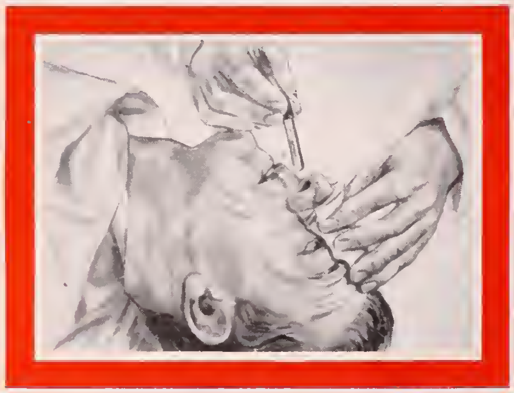


Drop Instillation



Lateral Head-Low Posture (Parkinson)



Displacement Therapy (Proetz)

Give Your Patients Specific Instructions for Privine

The unique chemical and pharmacological properties of Privine have been found to produce vasoconstriction of the peripheral vessels in approximately the same degree as epinephrine, but the effect persists for much longer periods of time . . . 2 to 6 hours. In general, only 2 to 3 drops in each nostril are needed to produce the full effect. Due to prolonged action, this dosage rarely needs to be repeated more often than every 4 hours. And to further lessen the possibility of secondary congestion, Privine, like other vasoconstrictors, should not be employed continuously over long periods of time. Vasomotor rhinitis patients who require extended therapy may be kept under observation, with interruption of treatment at intervals as required.

Redesigned Dropper Aids Correct Dosage

By instructing the patient in the apparently minor details of applying the appropriately small dosage of Privine, most satisfactory results are obtained. To aid in guarding against overdosage, all Privine prescriptions now contain a new dropper, the maximum capacity of which is approximately the recommended dose. This is in contrast to other droppers which can be overloaded with several times the proper amount. With the new dropper the patient is enabled to carry out automatically his physician's instructions in using Privine.

PRIVINE—TRADE MARK REG U S PAT OFF. AND CANADA

Ciba

Promote Drainage in Sinusitis with Privine's Prolonged Action!

The desirability of using a vasoconstrictor to promote and hasten drainage in acute or chronic sinusitis is well recognized. In choosing such an agent an increasing body of physicians has turned to Privine as a vasoconstrictor giving the desired action with a minimum of unpleasant side effects. The predominant place Privine holds today may be largely accounted for by the four advantages which follow:

PROLONGED ACTION. Privine's prolonged effect is particularly valued as an adjuvant to the therapy of sinusitis. The shrinkage of sinus ostia, taking place over a long period of time, results in a better opportunity for drainage.

FREEDOM FROM LOCAL IRRITATION. Privine is prepared in isotonic aqueous solution, *strongly* buffered to a pH of 6.2 to 6.3. It therefore closely simulates the normal nasal secretions. In its use there is no interference with the ciliary activity so essential in clearing the nasal passages of dust, pollen and bacteria.

EFFECTIVENESS IN SMALL DOSAGE. The small quantity of Privine necessary for effectiveness is an asset, providing economy, promoting ease and comfort in use...qualities appreciated by the physician and also by patients when directed to use Privine between office visits.

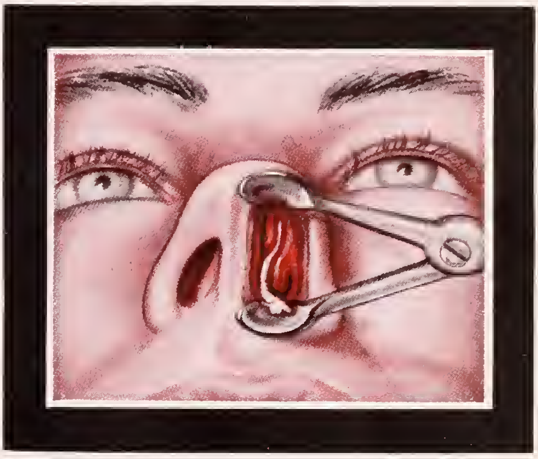
MINIMAL SIDE EFFECTS. The nervousness, tremor, palpitation and other side effects sometimes associated with the use of vasoconstrictors are rarely encountered when Privine is used in the advised dosage. This is particularly important when Privine is used before retiring, since there is little likelihood of interfering with restful sleep.

Supplied in Two Concentrations

Privine is issued in 0.1 per cent solution for adults only, and in 0.05 per cent solution for children and adults. Many physicians have found 0.05 per cent Privine a suitable concentration for the majority of patients, both adult and child.

Privine may be used by the drop instillation method, by tampon, and by the Proetz displacement technic. It may be used in atomizers, but should not be brought into contact with aluminum.

Ethmoidal Sinusitis



Frontal Sinusitis

Maxillary Sinusitis

Tomorrow BEGINS Today

2 cc. size
DIAL WITH
Pharmaceu
Summ

Awakening from Dial-induced slumber is *rarely marred by dullness or depression.* Dial induces a calm and refreshing sleep, usually followed by a sense of tranquillity and greater aptitude for the work of the day.

When mental agitation and nervous exhaustion cause insomnia, remember that a calm and efficient tomorrow begins today, and prescribe Dial. Dial may be taken during working hours in moderate doses when sedation is required.

Solution of Dial with Urethane is suggested when parenteral administration is desirable, as in obstetrical analgesia. Write Ciba Professional Service Division for samples and literature.

DIAL

AN EFFECTIVE AND RELIABLE SEDATIVE AND HYPNOTIC

Available—Dial Tablets: $\frac{1}{2}$ grain, bottles of 24 and 100; $1\frac{1}{2}$ grains, bottles of 15 and 100.

Dial with Urethane: 1 cc. ampuls, cartons of 5; 2 cc. ampuls, cartons of 5 and 20.

Steroid Hormones and Fine Pharmaceuticals

CIBA PHARMACEUTICAL PRODUCTS, INC.

SUMMIT, NEW JERSEY
In Canada: Ciba Company Limited, Montreal

Dial—Trade Mark Reg. U. S. Pat. Off. and Can. The word "Dial" identifies the product as diallylbarbituric acid of Ciba's manufacture

CEDILANID...LANATOSIDE C

FOR INTRAVENOUS AND ORAL DIGITALIS THERAPY

R. M. Tandowsky (American Heart Journal, January 1945) states: "The use of lanatoside C orally in preference to other preparations of digitalis seems reasonable because this drug acts with rapidity, yet with minimal toxic effect, and retains its pharmacologic potency in vivo for at least twenty-four hours. The effect of this drug has been demonstrated both electrocardiographically and clinically to be without variability, whereas other preparations of digitalis act with marked inconsistency. Furthermore, the toxic effects of this drug, when administered over a prolonged period of time, are less than those of other digitalis preparations in common use.

SUPPLIED

Tablets, each containing 0.5 mg. of Lanatoside C Ampuls, 4 cc. (i.v.) and 2 cc. (i.m.)

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Fully equipped for the diagnosis and modern treatment of diseases of the chest, including tuberculosis and other respiratory diseases

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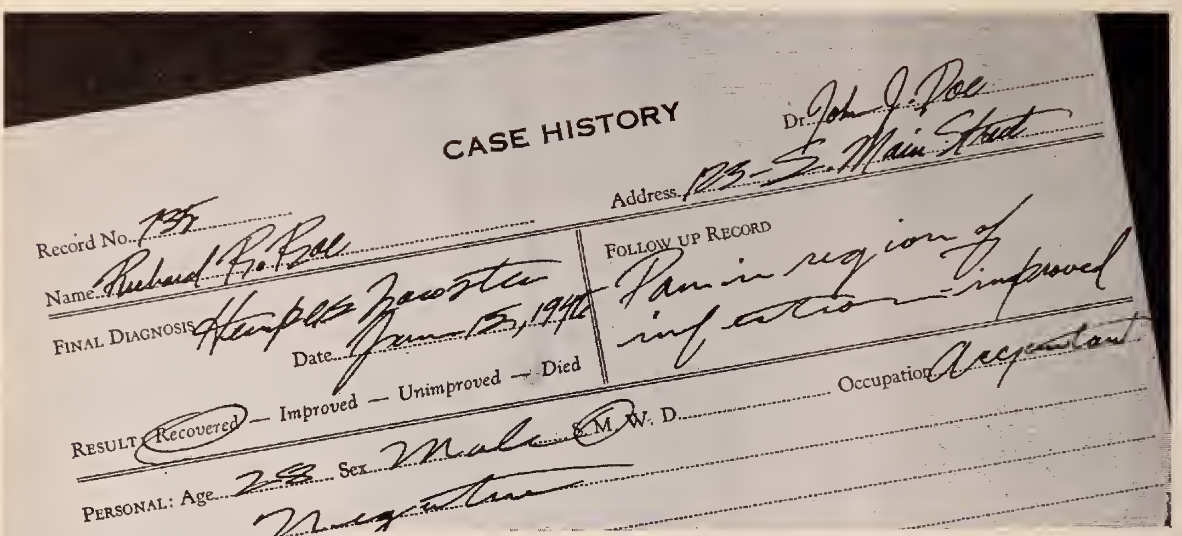

CASE HISTORY

Record No. 735

Dr. John J. Doe

Address 123 S. Main Street

Name Richard R. Roe

FINAL DIAGNOSIS Herpes Zoster

Date June 15, 1946

FOLLOW UP RECORD Pain in region of infection — improved

RESULT [✓ Recovered] — Improved — Unimproved — Died

PERSONAL: Age 23 Sex Male S [✓ M] W. D. Occupation Accountant

FAMILY HISTORY: Negative

HABITS:

PAST HEALTH:

PRESENT CONDITIC

PHYSICAL E

TEMP. 9

HEAD: (ir

CASE HISTORY OF THE 30% . . .

30% of members of California Medical Association served in World War II. Many already discharged and back to civilian practice. Some needed financial aid; to buy new equipment and reestablish practice, or to enter group practice; others to open their own offices. "G. I. Bill of Rights" guarantees 50%, or $2,000, of certain business loans to veterans. In its **Vet-loan Plan,** Bank of America includes and supplements "G. I. Bill." Many veteran doctors extended more kinds of credit than they anticipated. Convenient monthly payment schedules arranged, consistent with ability to repay.

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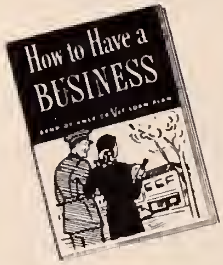

"How to Have a Business" and "Term Loans for Small Business" are two helpful Bank of America booklets which you might like to read. They are yours for the asking at any branch.

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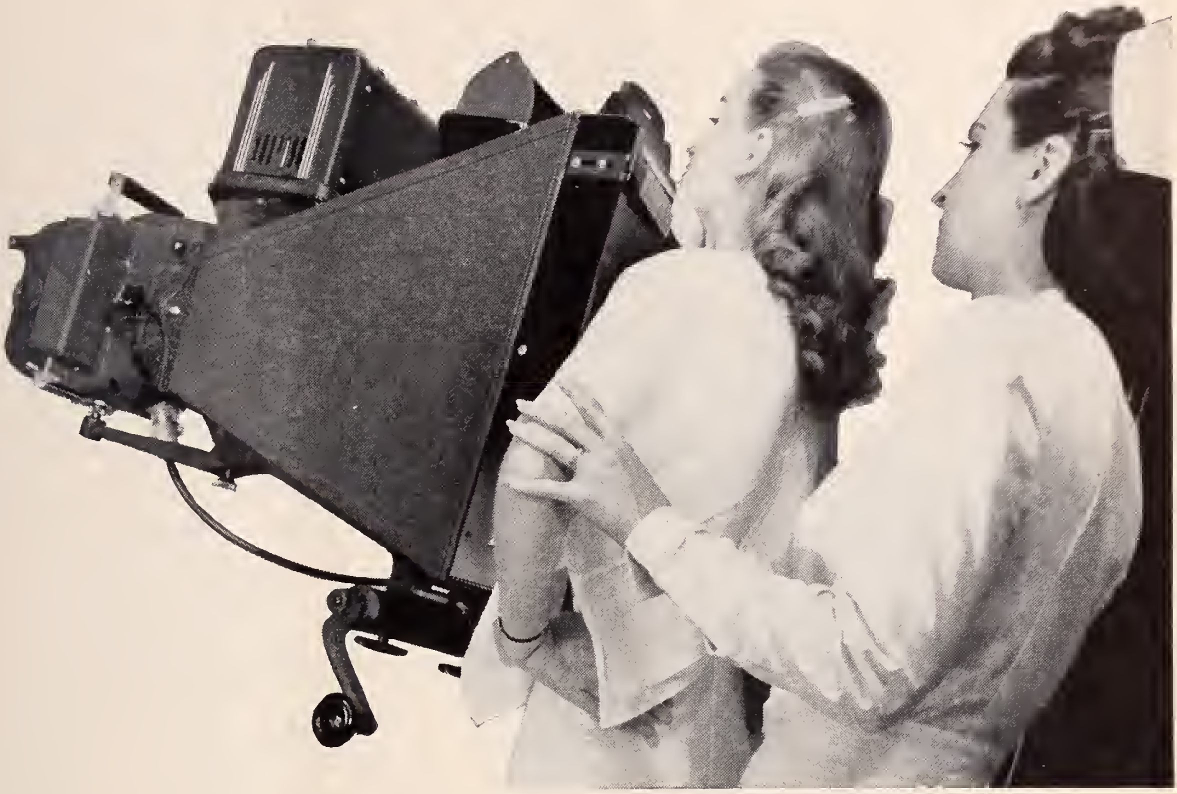
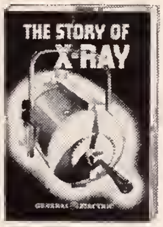
Is Your Community Awaiting an X-Ray Chest Survey?



Through well-directed educational campaigns sponsored by tuberculosis organizations throughout the nation, men, women, and children have been learning about technological developments which today make it economically feasible to conduct x-ray chest exminations of large groups of people for the purpose of detecting unsuspected tubercular infections in apparently healthy individuals.

Public interest having been so thoroughly aroused, many communities have adopted individually planned x-ray chest survey programs as a most effective measure for tuberculosis control—for screening out and isolating individuals who, "ignorant of the fact that they have the disease, unknowingly jeopardize their own lives and the lives of those with whom they come in contact."

Come the time when such a survey is suggested for your community, and your professional advice probably sought by the local tuberculosis society, we shall be glad to help you prepare a summary which would evaluate the various methods and facilities used for different types of chest surveys. These evaluations, may we assure you, will be unprejudiced, as G-E photo-roentgen apparatus is not limited to but one model, nor restricted to the use of one size of film. Address General Electric X-Ray Corporation, 175 W. Jackson Blvd., Chicago 4, Illinois.



For Your Reception Room—this booklet will prove of absorbing interest to waiting patients. It commemorates the 50th Anniversary of the discovery of x-ray, and recounts the notable contributions of x-ray science, not only to medicine but also to many important phases of industry. Send for your complimentary copy. Ask for Pub. C13.

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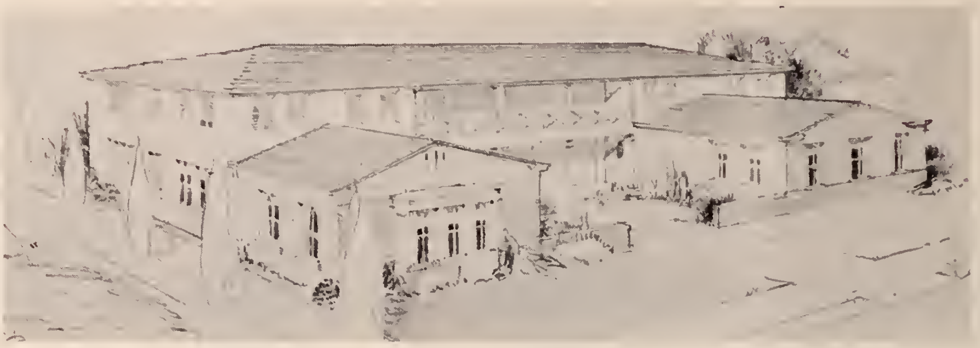

Construction on the building pictured above will start in March. An eleven-man specialists' building, it is being built by Doctor Suren H. Babington. Residential type, set in artistic surroundings, it will have all outside rooms, an inviting vestibule, with a niche fountain and a patio and garden. Site for the structure will be on Ward Street in Berkeley, 100 yards from the Southwest corner of Telegraph Avenue. All eleven men will be practicing a different specialty without any duplications. Applications are being accepted for the remaining suites.

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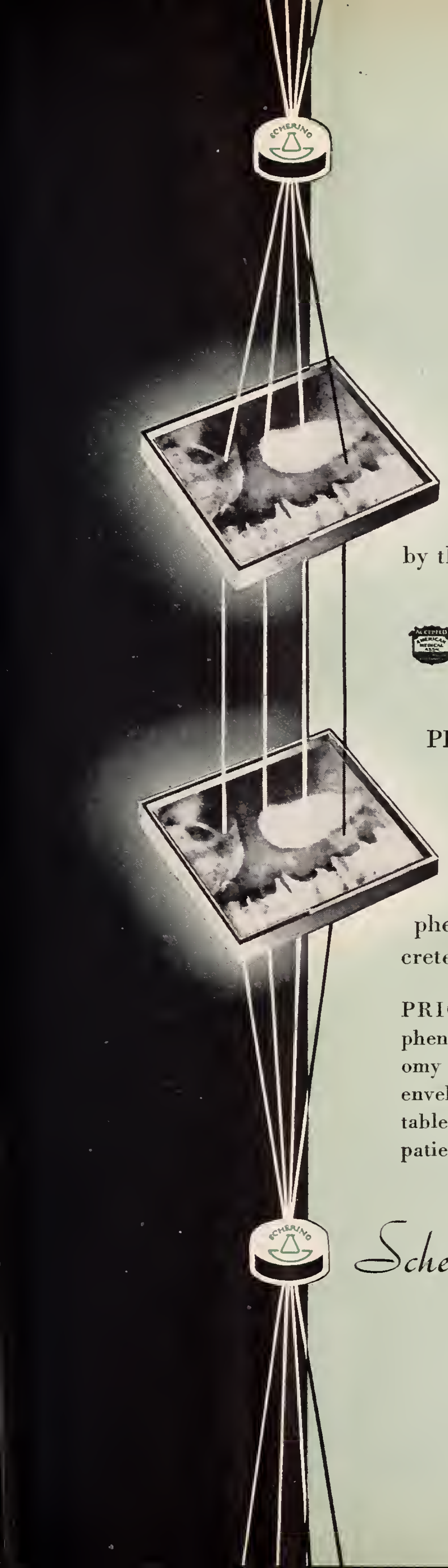

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

From an Article on "Stiffness in the Extremities Followed by Accident and Injury," by A. L. Fisher, M.D., San Francisco.—The object of this paper is to attempt to classify some of the causes of stiffness following injuries to and operations on the extremities.

We are all familiar with the fact that after operation or injury stiffness is one of the most disagreeable and trying symptoms that arises. Stiffness may be due to lesions in practically any or all of the structures that go to make up the extremity. The first stiffness of which a patient complains after immobilization of the part, particularly in the lower extremity, is due to oedema—lack of vascular tone and muscular activity. When this is the only cause the condition is temporary and with resumption of muscular activity soon passes off. . . .

From an Article on "Recent Developments in Radium Therapy," by Rex Duncan, M.D., Los Angeles.—The past five years have seen great advancement in radium therapy equal to, if not greater than that of any other branch of medicine. This has resulted not so much from our increased knowledge of the physical properties of radium, as from the better application of this knowledge and more particularly from a careful study and better understanding of the histological changes produced in both normal and abnormal tissues.

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From an Article on "Teeth, Tonsils and Sinuses," by Robert B. Sweet, M.D., Long Beach.—The object of this

(Continued in Back Advertising Section, Page 34)

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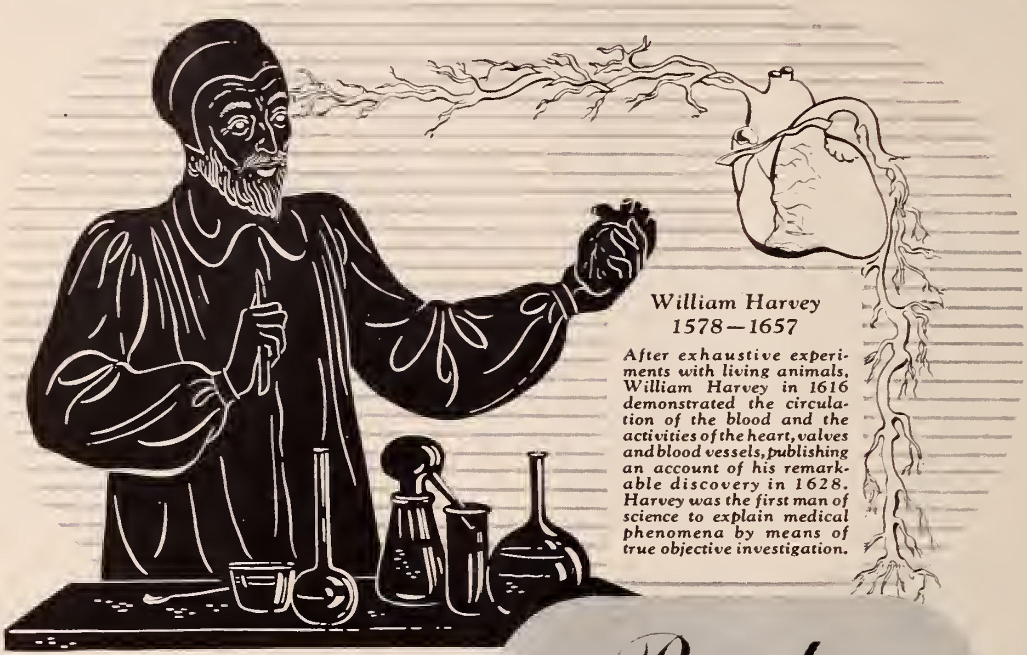

William Harvey
1578—1657

After exhaustive experiments with living animals, William Harvey in 1616 demonstrated the circulation of the blood and the activities of the heart, valves and blood vessels, publishing an account of his remarkable discovery in 1628. Harvey was the first man of science to explain medical phenomena by means of true objective investigation.

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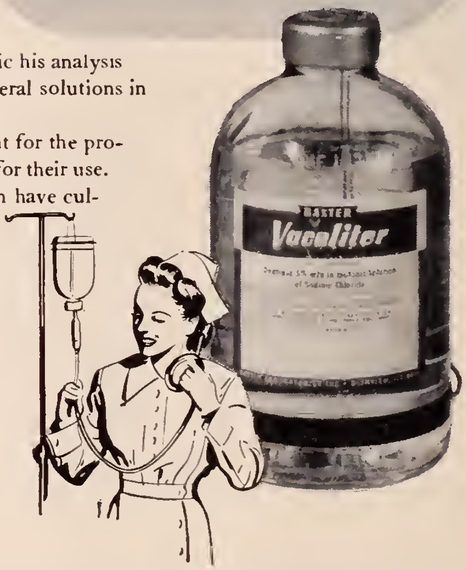

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*Anderson, Geo. K., M.D.: *The Importance of Protein in Diet Therapy,* J. Am. Dietet. A. 21:436 (July-August) 1945.

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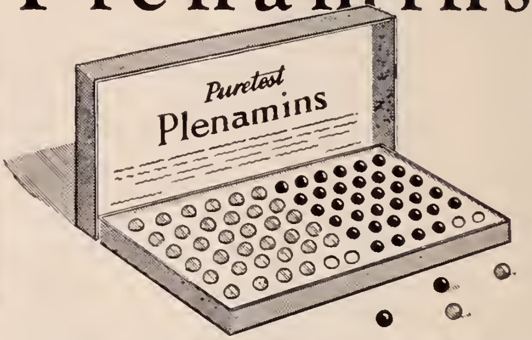

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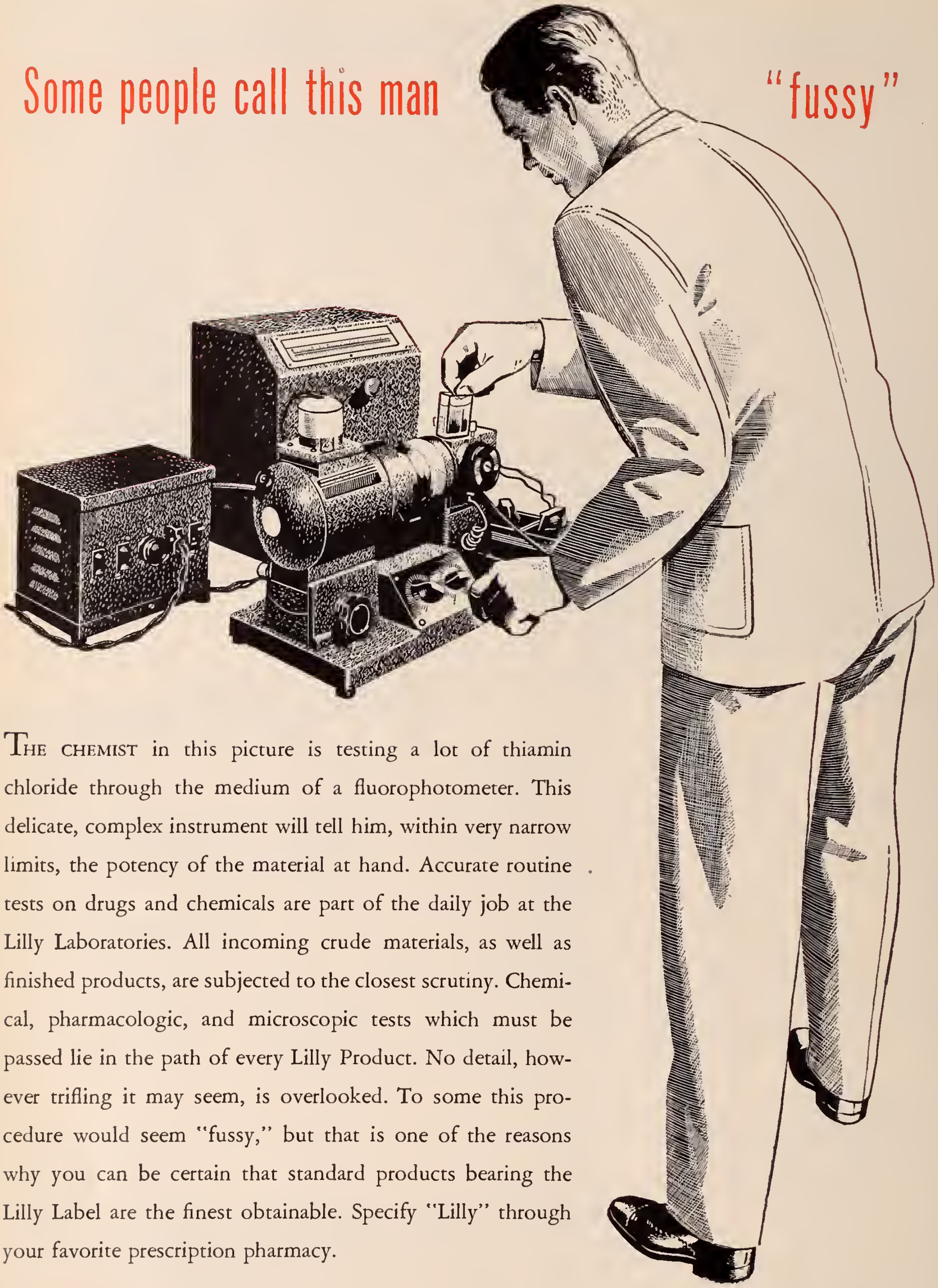
Some people call this man "fussy"



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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 64 MARCH, 1946 NO. 3

California and Western Medicine

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Four Fifty Sutter, Room 2004, San Francisco
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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . GEORGE H. KRESS, M. D.

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

Committee on Publications

George W. Walker, Chairman..........Fresno 1946
F. Burton Jones......................Vallejo 1947
R. H. Sundberg.......................San Diego 1948
George H. Kress, Secretary-Editor.......San Francisco ex officio

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . . . JOHN HUNTON
Advertising Representative for Northern California
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Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

INDOCTRINATION COURSE FOR APPLICANTS TO COUNTY MEDICAL SOCIETY MEMBERSHIP—LOS ANGELES COUNTY MEDICAL ASSOCIATION INAUGURATES A CONSTRUCTIVE PLAN

World Unrest Makes for Social Unrest and Changes.—In all places and at all times, acute variations in modes of government or living have brought into being new methods of procedure; the changes being designed to create better harmony with conditions that may have undergone rapid and extensive variation.

An example of such a phenomenon may be noted in the different outlook and orientation now almost everywhere held on national and international relationships. These have grown up through observation of the dreadful costs in human suffering and lives, and the vast devastation of material resources that have taken place in both occidental and oriental countries.

For today, it may be said that European and Occidental civilizations are in a state of flux,—in some places more, in others less—but everywhere in sufficient amount to influence the present and future living of millions of human beings.

* * *

Medical Practice is also Faced with Changes.—Since such conditions exist, it is not surprising that the healing art profession should now find itself called upon to solve new and difficult problems in medical organization and economics; on matters which, a brief quarter of a century ago, were not given even a passing thought by perhaps eight out of every ten Doctors of Medicine.

The significance of such a state of affairs is this:—That many, perhaps a majority of physicians, who are now being called upon to consider plans that could make great changes in individual and collective medical practice,—do not possess the background of knowledge on medical economics and public relations to enable them to form quick and satisfactory conclusions on proposed methods of practice, that are radically different from those to which they have been accustomed since their undergraduate days.

While many individual physicians have failed to sense the significance of these impending innovations, such have been appreciated, however, by many medical organizations and their administrative officers.

County Medical Societies Can Lay Foundation for Better Understanding.—How to lay the foundation for a better understanding by all physicians of the problems now confronting the medical profession has been much discussed during the last two or three decades. Many plans have been proposed but few have been accepted or tried out. Recently, one of the component county medical units of the California Medical Association—that of Los Angeles—has announced and put into operation its "Indoctrination Plan," —a procedure that is certainly thought-stimulating.

There may be some who would contend that what is being attempted in Los Angeles is an activity more properly a function of every medical school. Perhaps so, but since the medical schools of the United States have given little more than lip service to their responsibilities in this work, it follows that the next line of attack must be, not with the undergraduate student, but with the individual upon whom the M.D. degree has already been bestowed by a medical school.

* * *

County Medical Societies are Sole Judges of Membership Applicants. — The question then arises,—What are the ways and means through which Doctors of Medicine may be contacted and put in better harmony with changes now taking place?

The answer is,—Through the County Medical Societies, since practically all physicians do or should aspire for membership in the organizations that are made up of their fellow physicians who have joined together in collective effort; in order better to promote an improvement in the service quality of both scientific medicine and public health activities.

Fortunately, membership in the national and state medical societies may only be secured through prior membership in a component county medical society. The county medical units possess the sole, absolute, and independent authority on who, and under what conditions an applicant physician may be granted membership relations. Since the county medical societies possess these rights, they also have the obligation to demand that all physicians whom they do admit into membership shall have not only proper scientific and ethical qualifications, but also an adequate understanding and outlook on medical organization, economics and public relations. While it is true that individuals contribute much to the advancement of scientific medicine, the end results depend in good part upon the collective or mass work of physicians.

* * *

What is the "Indoctrination Plan" of the Los Angeles County Medical Association?—What has been written above, is a sort of prelude to presentation of the significant plan recently instituted by the third largest county medical association in the United States—that of Los Angeles. (For statistics, see page 136.)

The story of the aspirations of that important county unit—exceeded in membership numbers by only 9 constituent state medical societies of the American Medical Association—is best told perhaps in excerpts from editorials and articles that have appeared in *The Bulletin* of the Los Angeles County Medical Association.

It is to be hoped that members will take the time to read these, and to ask themselves whether in their own county medical organizations, somewhat similar plans could not be tried.

The excerpts follow:

⁂

(1) From *The Bulletin* of October 4, 1945:

That every applicant for membership in a component county medical association should be required to attend a course of lectures designed to indoctrinate him thoroughly in certain aspects of the successful practice of medicine, was the substance of a resolution recently adopted by the Council of the California Medical Association. The plan was discussed by the Council of the Los Angeles County Medical Association at its last meeting.

If the program is accepted, every physician who seeks membership will be required to attend and to pass an examination on the subject matter of a series of lectures by qualified instructors in professional ethics, malpractice prophylaxis, laws governing medical practice and narcotics, the state poison act, public health ordinances, and laws governing birth, death and other certificates. The history of our county medical association—its aims, accomplishments and struggles—should be taught to every new member. Each applicant should become familiar with the work of the Physicians' Aid Association and the Medical Milk Commission. He would also derive benefit from information concerning the county hospital, the health department, the coroner's office, workmens' compensation laws and proper conduct as an expert witness.

⁂

(2) From *The Bulletin* of December 20, 1945:

Indoctrination.—Each new applicant for membership in the Los Angeles County Medical Association will henceforth be required to attend a course of lectures by qualified instructors, designed to augment his knowledge of California laws affecting the practice of medicine, of malpractice prophylaxis, of professional ethics and courtesy, of the Association's history, accomplishments and aims, and of other essential subjects. This, the so-called "Indoctrination Plan," was discussed more fully on this page in *The Bulletin* of October 4, 1945. The Council, at its meeting on December 3, ordered that the program be instituted forthwith and instructed President J. J. Crane to appoint a committee to outline and supervise the required course of instruction.

The number of lectures to be given, the topics, the lecturers, and the scope of the examination will be determined by the committee. It is believed that this instruction will be of material value, not only to young physicians but to those from outside the State who are unfamiliar with customs and conditions in California. The applicant will also obtain a knowledge of the Association and its activities which should encourage his active participation in its work from the beginning of his career.

This has become increasingly difficult as the number of applicants has increased. Membership in this Association is a valuable and coveted asset. It should be granted only to physicians of high character and ability, whose careers will add to the lustre of that membership. The Association has no need of those whose business methods, habits, or lack of ability have made them failures elsewhere.

(3) From *The Bulletin* of the Los Angeles County Medical Association, issue of February 7, 1946:

A change in the procedure admitting applicants to membership in the Los Angeles County Medical Association was approved by the Council at its December meeting. At that meeting a committee known as a General Committee on Indoctrination was appointed: Dr. Jay J. Crane, Chairman, and Doctor L. A. Alesen, Howard W. Bosworth, E. T. Remmen, and Paul D. Quaintance.

The committee was instructed to develop and to put into effect a program providing for a series of lectures on subjects of importance to all doctors of medicine seeking membership in the Association—attendance of applicants at these lectures being necessary before their applications would be considered by the Council.

The General Committee on Indoctrination, at its first meeting January 14, announced the appointment of the following sub-committees — each sub-committee charged with presenting one of the six lecture courses:

On Medical Organization
E. T. Remmen, M.D., Chairman
On Health Insurance
Lowell S. Goin, M.D., Chairman
On Medical Public Relations
Paul A. Quaintance, M.D., Chairman
On Medical Ethics
Donald A. Charnock, M.D., Chairman
On Medical Education and Medical Economics
L. A. Alesen, M.D., Chairman
On Medical Malpractice
Donald G. Tollefson, M.D., Chairman

These lectures will be presented in the lounge of the Association, beginning promptly at 7:30 o'clock on the 3rd and 4th Friday evenings of each month. The first lecture was presented January 25.

Dr. Regan stated that each chairman of the various sub-committees had assumed the responsibility of preparing a lecture. Following the lecture the applicants will have the privilege of asking questions. Dr. Regan expressed the hope that all members of the sub-committee presenting a subject at a given meeting, would attend that meeting.

Dr. Remmen said that a major objective sought in this program was that members of the committees could become acquainted with the applicants. He recommended that the meetings be so arranged that committee members would have the opportunity to interview the applicants to determine their attitude toward the Association, and to gain further information about their background.

Dr. Crowe moved that the plan as presented by Dr. Regan, including the composition and activities of the various committees, be approved by the General Indoctrination Committee. This motion was seconded and unanimously passed.

TWO IMPORTANT MEDICAL CONVENTIONS IN CALIFORNIA THIS YEAR—C.M.A. AT LOS ANGELES, MAY 7-10; A.M.A. IN SAN FRANCISCO, JULY 1-5

Los Angeles Session Will Transact Important Business.—Now that VE and VJ days are behind us, California Medical Association will change in this year, 1946, from a two-day and streamlined week-end annual session, to one of four days duration.

Place will be Hotel Biltmore in Los Angeles; the dates, Tuesday, May 7 through Friday, May 10.

The C.M.A. Committee on Scientific Work and Section Officers have been somewhat handicapped in the preparation of the scientific programs, because many members have been in military service, and the conditions under which civilian physicians have been carrying on their work, have not given much time for research and special studies.

It is hoped, however, to present scientific addresses, papers and panel discussions that will have appeal, and be of up-to-date interest and value. The complete programs will appear in the April issue of CALIFORNIA AND WESTERN MEDICINE.

Much important business will be presented for consideration, to both the House of Delegates of the California Medical Association and Administrative Members of California Physicians' Service.

Social events will not be entirely forgotten. The dinner reception to retiring President Philip K. Gilman will take place in the Biltmore Bowl, where a large attendance of one thousand persons is almost a certainty.

C.M.A. members are requested to make note of the days of the meetings, and to arrange their schedules to permit attendance, if at all possible.

Younger members and physicians who have taken up their residence in California during the last several years are especially urged to attend; to learn for themselves the benefits that may be derived through contacts with fellow physicians, in both scientific and good fellowship conferences.

* * *

American Medical Session will Follow, in July, at San Francisco.—The 74th annual session of the American Medical Association was held in San Francisco June 25-29, 1923, and the 94th annual convention, June 13-17, 1938. This year's annual conference of the A.M.A. will convene in San Francisco on Monday, July 1 and carry on through Friday, July 5.

According to A.M.A. custom, the local county medical association — San Francisco County Medical Society—rather than the California Medical Association will be the host of honor; although both organizations will work in close relationship in order to make this San Francisco session a great success.

Dr. John W. Cline was nominated to be chairman of the Committee on Arrangements, and with his associates, he has gotten arrangements in good hand.

Because this is the first opportunity since beginning of World War II, for physicians throughout the United States to meet in annual conference, after the manner of former years, and because many physicians who have been working under stress and strain during the war years need a vacation, there is every indication that the attendance at the annual A.M.A. session in July will be unusually large.

California physicians who have never attended an annual conference of the national medical organization should not miss this opportunity to be present, to better acquaint themselves with the bigness and broadness of the scientific and organizational activities of the American Medical Association.

STATE UNIVERSITY MEDICAL SCHOOLS IN SAN FRANCISCO AND LOS ANGELES RECEIVE SUBSTANTIAL APPROPRIATIONS FROM CALIFORNIA LEGISLATURE

A New State University Medical School in Los Angeles.—Medical Education in California will have reason to record, A. D. 1946,—for in this current year, a new medical school has been created, as one of the departments of the University of California. The new institution will be located in Los Angeles,—perhaps as a professional school allied to the "University of California at Los Angeles." In California and Western Medicine for February, the proposed school received comment on page 66.

Governor Earl Warren signed on Wednesday, February 20, the initial appropriation bill for $7,500,000, enacted by the California Legislature.

Physicians throughout California welcome this new and much needed medical institution, and good wishes are voiced for a long and prosperous career. Congratulations are also extended to the group of medical and other citizens who carried on the campaign of education to show the need of an additional medical school in California, and to Governor Earl Warren for his generous support of the plan.

* * *

University of California Medical School in San Francisco.—Old Toland College of San Francisco (1862-1906), absorbed by University of California in 1906, and since that time of increasing growth and influence, operating in buildings on the former Affiliated Colleges site, now known as San Francisco Medical Center, also receives a substantial addition to its capital funds. The Legislature approved Assemblyman Gardiner Johnson's bill for a $4,000,000 appropriation, and on Wednesday, March 6, 1946, Governor Earl Warren signed the Act and made the money available. (For plan of buildings, see page 142.)

In addition, from former war-year sessions of the Legislature will come about $2,000,000 that was earmarked for additional construction and facilities at the Medical Center; and designed to meet needs in the Medical Library and Departments of Dentistry and Pharmacy, and School of Nursing. (See in this issue, on page 141.)

For these appropriations to further develop the facilities and opportunities for service at the University of California Medical School in San Francisco, appreciation is likewise expressed by the medical profession.

V.A.-C.P.S.: PLAN WILL BE IN ACTIVE OPERATION IN MARCH

Regional Offices Will Permit Early Operation of the V.A.-C.P.S. Plan.—In the February issue of the Official Journal, the opening editorial referred to the important contract entered into between Federal Veterans' Administration and California Physicians' Service.

In the current issue, appears the fee schedule mutually accepted. (See page 144.)

Members should scan this schedule to convince themselves the fees that will be received for professional services to be rendered to soldiers and sailors of all recent wars (Spanish-American, World War I and World War II)—to whom all of us are under massive obligation—are equitable; and with certainty of payment, all that could, in fairness, be asked from the Government.

It is possible that California may shortly have within its borders as residents, as many as 2,000,000 veterans. This is a large segment of California's population, and a governmental plan that permits maintenance of private practice and individual physician-patient relationship for so many citizens, plus affiliations with their families and friends, is something, in troublous times such as the present, that is worthy of gratulation to all concerned.

The V.A. officers are establishing two regional bureaus in California, one for the northern and the other for the southern section of the State. To permit prompt checking and to expedite giving of professional services to eligible veterans by C.P.S. members, a V.A. physician with his own clerical aides has already been assigned to each of the C.P.S. offices in San Francisco and Los Angeles.

Pharmaceutical Profession Studying Medical Service Plans

The American Pharmaceutical Association and the National Association of Retail Druggists have appointed a Joint Committee to study various plans proposed to provide medical care in which either the insurance principle is applied, or in which state funds or federal funds are made available.

The purpose of this study is to determine the extent to which pharmacists and pharmaceutical associations may participate in working out these plans or suggesting modifications or substitutes for them.

The Committee has no preconceived ideas as to the recommendations which it wishes to make to the pharmacists of the Nation on this subject. It wishes to make a factual study of available plans and procedures and report the facts as they are found to the two national organizations as a basis for possible action.

Antonj Van Leeuwenhoek (1632-1723). — While Leeuwenhoek was not a physician and had no formal scientific training, he was a very great microscopist and contributed many "firsts" to the progress of medicine. Among them are his accurate representation of bacteria, spermatozoa, red blood cells, parasitic and entozoic protozoa; and a complete demonstration of the capillary connection between arteries and veins, providing the final link in the chain of Harvey's discovery of the circulation of the blood. His microscopes, which he made himself, had a maximum magnification of 160 diameters.—Warner's *Calendar of Medical History.*

EDITORIAL COMMENT†

DIETARY CONTROL OF RENAL HYPERTENSION

In 1944 Grollman[1] of the Department of Experimental Medicine, Dallas, Texas, suggested a simplified method for the production of chronic renal hypertension in the mouse, rat, rabbit and dog. The method consisted essentially in passing a loop of cotton thread or tape over the two poles and body of the kidney and tightening the ligature sufficiently to deform normal kidney shape. He found that about 20 per cent of the rats and rabbits develop a moderate degree of hypertension following such compression of a single kidney. About 70 per cent develop pronounced hypertension following bilateral renal compression.

In a typical experiment on dogs, the blood pressure rose from a normal of about 12 mm. Hg. to 150 mm. Hg. during the first two months after unilateral renal compression. The second kidney was then compressed, following which the pressure rose to 200 mm. Hg. The maximum was reached by the end of one year. The pressure remained at this high level for the next 8 months during which the animal was under observation. In rats a chronic hypertension of about 170 mm. Hg. was regularly produced by similar bilateral compression.

The ease and regularity with which hypertension can be produced in rats led Grollman[2] to select these animals for a study of the possible therapeutic effects of various types of diet. In a typical experiment pulverized Rockland Farm rat ration was dialyzed for 4 to 5 days, till all chlorides had been removed. The dried dialyzed diet was then enriched with synthetic vitamins (thiamin, riboflavin, hexabione, calcium pantothenate and niacin), cod-liver oil, and Osborne-Mendel salt mixture from which all sodium salts had been excluded. Twelve hypertensive rats, whose average blood pressure was 17 mm. Hg. were changed from the routine laboratory diet to this dialyzed food. Within 6 days their average blood pressure had fallen to 125 mm. Hg., at which low level it remained till the end of the experiment (18 days). On returning these rats to the routine stock diet, the hypertensive state was restored quantitatively within 6 days. Similar lowering of the hypertensive state was noted in rats placed on a diet composed entirely of ground peanuts, soy beans, rice and potatoes.

In attempts to determine the essential factor in this therapeutic effect it was found that the anti-hypertensive properties of the dialyzed diets could be completely destroyed by the addition of 1 per cent NaCl, while its anti-hypertensive titer was not reduced by the addition of 1 per cent KCl. From this and other data it seemed probable that radical sodium restriction is the essential factor in overcoming renal hypertension in rats.

In order to determine whether or not the marked reduction in blood pressure induced by radical sodium restriction for long periods of time is deleterious to previously hypertensive animals, 62 hypertensive rats were divided into 2 equal groups, matched as to their blood pressure. One group received the regular stock diet. The other group was given the dialyzed low sodium diet. By the end of 100 days, but 8 (or 25 per cent) of the regularly fed rats had survived. The concurrent survival rate in the low-sodium group was twice as great, i.e., 15 rats (or 50 per cent). The low-sodium, anti-hypertensive diet is thus apparently beneficial insofar as duration of life is concerned.

The mechanism of the anti-hypertensive effects of sodium restriction has not yet been determined. It is known that there is a "dry edema" or accumulation of salt and water in the tissues of hypertensive patients. Grollman postulates that when subjected to a drastic sodium restriction the hypertensive rats rid themselves of this plethora of salt and water in the fixed tissues, with a secondary reduction in blood pressure. This and other suggested possibilities are now under investigation.

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TELEKINETIC ANTIBODY REACTION

A revolutionary new theory of antigen-antibody reaction is suggested by Rothen[1] of the Rockefeller Institute as a result of his studies of the physio-chemical properties of multimolecular antigenic films.

About ten years ago Langmuir[2] and associates developed a method of transferring materials spread as a monomolecular film on a bath surface to highly polished stainless steel slides. The transferred material was held in place by a thin layer ("reference film") of barium stearate, uranyl acetate or other adhesive material. Thus transferred the mono-film may be subjected to chemical reactions and the resulting changes in its thickness measured by optical methods.

Chambers[3] and his associates of the University of Pennsylvania, adapted the Langmuir technique to the preparation of monomolecular and multimolecular films of bacterial antigens. They exposed these immobilized or fixed antigenic films to specific immune serum. After thoroughly washing the exposed slides with saline solution and distilled water, the increased film thickness resulting from union with homologous antibodies was measured by refraction methods. Control tests were made with normal serum and with heterologous antiserums.

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† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

Adopting the Chambers technique Rothen and Landsteiner[4] of the Rockefeller Institute found that a monomolecular layer of bovine albumen 6 to 8 Å thick, would attract and hold firmly a sufficient amount of antibovine antibody to increase the thickness of the film by about 40 Å. Heterologous antibodies gave no appreciable increase. This means that a single layer of bovine albumen would attract and firmly hold about 10 superimposed layers of specific antibody. In this latest work Rothen[1] tested multimolecular films. He found that if the number of bovine albumen layers was increased to 2, the thickness of the adherent antibody film was increased to about 60 Å. With 4 bovine antigenic layers the increase was to 104 Å, and with 8 layers to 149 Å. Control tests with heterologous (anti-egg-albumen) antibody gave negligible increases.

These data show that the effective range of specific attraction between antigen and antibody is "in the order of hundreds of Å." Rothen found that this telekinetic attraction is effective through a thin biological membrane. He tested membranes consisting of 6 to 10 superimposed layers of egg albumin. Through this egg albumin screen the antigen would attract and firmly hold as much as 86 Å of homologous specific antibody.

Rothen offers no theory to explain this presumptive telekinesis. He believes, however, that it is of "major importance from the standpoint of biology, [since] the reaction offers a very interesting example of the physical forces involved between large molecules." If so, the implied specific electrodynamic attraction sphere surrounding each protein molecule would have numerous basic applications in physiological and biochemical research. It might render many of the conventional theories of immunity of little more than historic interest and would have numerous other clinical applications. These and other suggested possibilities are now under investigation.

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Casimir-Joseph Davaine (1812-1882).—"I congratulate myself to have so often been the follower of your scientific researches"—wrote Pasteur to the man who, with Rayer, was the first to see the bacillus of anthrax. This French pathologist, parasitologist, and experimenter, was an initiator in every sense of the word. His treatise on animal parasites of man and domestic animals was an important one, as were those on infective diseases and septicemia.—Warner's *Calendar of Medical History.*

American Medical Association Plans a National Sickness Insurance Program

Organized medicine, through the Board of Trustees of the American Medical Association, on February 16, announced preliminary plans for the development of a nationwide system of voluntary sickness insurance protection, to be operated on a non-profit basis by local medical groups.

* * *

Details of the program, including costs, benefits and standards, now are being worked out by a newly formed subsidiary federation, known as Associated Medical Care Plans, Inc. Details should be ready for early release to the public.

While premium charges will vary in different parts of the country, the average cost to any individual policy holder will be "considerably less" than the $144 annual payroll deduction suggested under President Truman's compulsory health insurance program.

* * *

In setting up standards of acceptance for voluntary prepayment medical and hospital care plans now in operation, the trustees and the A.M.A. Council on Medical Care, have decried all such plans must meet the following requirements before they may display the Association's seal of approval.

(1) Have the approval of the State or county medical society in the area in which they operate.

(2) The medical profession in the area must assume responsibility for the medical services included in the benefits.

(3) Provide free choice of a qualified doctor of medicine, and maintain the personal, confidential relationship between patient and physician.

4) Be organized and operated to provide the greatest possible benefits in medical care to the subscriber.

* * *

Benefits under any of the plans, it was stated, may be in terms of either cash indemnity or in units of medical service. A house call would count for so many units and a visit to the physician's office would count for a varying number of service points.

The subsidiary medical plans care group, which is engaged in coördinating the various prepayment programs now in operation, also will seek to establish a reciprocal relation among all plans to permit subscribers to transfer their membership from one state to another. A central clearing house is to be located at A.M.A. headquarters in Chicago.

Seven Times As Many People Now Own Life Insurance As In 1900

Year	*Number of Policyholders*	*Average Amount Owned Per Policyholder*
1900	10,000,000	$860
1918	31,000,000	$960
After World War I		
1945	71,000,000	$2,175
After World War II		

Despite the fact that seven times as many people own life insurance now as in 1900, there are fewer full-time ordinary life insurance agents in the business. The number of full-time agents decreased 31 per cent since the start of World War II. In the past year new full-time ordinary life agents entering the business were 55 per cent fewer than in 1940, according to the annual census of life insurance agents, just released by the Life Insurance Agency Management Association of Hartford. Ordinary companies showed a 40 per cent increase in sales of new insurance during the six-year period in spite of the decrease in agents.

ORIGINAL ARTICLES

Scientific and General

CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH: ITS ADMINISTRATIVE ORGANIZATION*

WILTON L. HALVERSON, M. D.
San Francisco

THE California State Department of Public Health, which is the second oldest in the nation, was established on April 15, 1870, only 20 years after the formation of the State government.

The first State Board of Health consisted of seven physicians appointed by the Governor and was primarily an advisory and informational body with exceedingly limited powers. In 1905 the Legislature expanded these powers to provide for bureau organization. From time to time additional bureaus and divisions were established under the supervision of the board.

The State Board of Health now consists of eight members: seven physicians, including the director of the department, and one dentist. Members are appointed by the Governor for four-year terms, so staggered that there are always some experienced members to give continuity to policy. The board functions as a policy-making, regulatory, judicial, and licensing body.

The State Director of Public Health is the executive officer of the board and the administrative head of the department. It is his duty to administer the laws and regulations of the board pertaining to public health, to observe sanitary and public health conditions throughout the State, and to take all necessary precautions to protect the State in its sanitary and public health relations with other states and countries.

The legal duties of the Department of Public Health include: Examination into the causes of communicable disease in man and domestic animals; investigation of the sources of morbidity and mortality and the effects of localities, employments, conditions and circumstances on the public health; licensing of hospitals coming under the Hospital Act of 1945; detection and prevention of adulteration of food and drugs; examination for and the prevention of pollution of sources of public water and ice supplies; and preparation and distribution at cost of antitoxins, vaccine, and other approved biologic products for the control or prevention of communicable disease. The department may advise all local health authorities, and, when in its judgment the public health is menaced, it shall control and regulate their action.

The State department has as one of its principal functions the encouragement and stimulation of local health departments capable of meeting the public health needs of the areas which they serve. Direct public health service to the people of California is given mainly by local public health departments, the State department giving only such direct service as cannot be provided locally. The chief way in which the department works toward the accomplishment of adequate local health departments is through providing the following services:

1. Leadership in assisting communities to recognize their public health needs;

2. Financial aid in the establishment and strengthening of local health services, including the provision of staff and other resources;

3. Provision of educational opportunities for staffs of local health departments;

4. Establishment of standards of service and personnel; and

5. Coördination of the total public health program within the State and of local, State, and Federal programs.

In January, 1945, the administrative structure of the Department was reorganized by the Director with the approval of the Governor. The activities of the Department are now conducted by five Divisions with supervision over fourteen Bureaus.

DIVISION OF ADMINISTRATION

The Division of Administration includes three bureaus: Business Management, Records and Statistics, and Health Education.

The Bureau of Business Management is responsible for fiscal and personnel control, accounting, and office management.

The Bureau of Records and Statistics is now responsible for registration and analysis of births, deaths, and marriages. It is planned that the bureau will be responsible for the recording and analysis not only of vital statistics but also of morbidity and service records.

The Bureau of Health Education conducts a Statewide program of education of the public on health problems and fosters local community organization for the solution of public health problems through education. Working with the State Department of Education and local health and school departments, it also seeks to improve the quality of school health services and instruction.

DIVISION OF PREVENTIVE MEDICAL SERVICE

The Division of Preventive Medical Service includes six bureaus.

The Bureau of Maternal and Child Health conducts activities for the improvement of the health of mothers and children, such as conferences and clinics in areas where such services are not supplied locally; enforces board regulations pertaining to institutions receiving maternity cases; conducts the State program for the aid of crippled children; administers the emergency maternal and infant care program which provides medical and hospital care for the wives and infants of servicemen; and registers school audiometrists.

The Bureau of Tuberculosis coördinates the Statewide program for the prevention and treatment of tuberculosis. Its chief services are the establishment and maintenance of high standards in sanatoria throughout the State, the administration of the State subsidy law, the conduct of x-ray surveys, and the development of effective case finding services.

The Bureau of Venereal Diseases administers the venereal disease control program which includes considerable Federal and State financial assistance to local health departments conducting venereal disease case-finding programs and free public clinics and laboratories. It administers the laws requiring premarital and prenatal examinations for syphilis.

California law requires the reporting of 52 different communicable diseases to the local health officer who in turn must report all such cases to the State Department of Public Health. The Bureau of Acute Communicable Diseases records the number of cases of each reportable disease, the total number of deaths caused by the disease, the age and racial distribution, the localities in which the disease occurred, and other information of this kind. From these records, trends of diseases are determined which are useful to the State and local authorities in planning their programs for the improvement of the public health and to control or prevent epidemics. Through immediate knowledge of an outbreak of a disease, the bureau is enabled to take action to prevent spread, and, in some cases, to remove the cause.

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* An official statement appearing in "California's Health," official bulletin of the California State Department of Public Health.

The Bureau of Public Health Nursing is responsible for the development and maintenance of high standards in public health nursing throughout the State. To accomplish this objective, the bureau assists local health departments and other agencies to obtain qualified public health nurses; offers advisory service to public health nurses and local health agencies; and maintains an educational program open to all public health nurses in the State.

The Bureau of Adult Health is responsible for programs for the protection of the health of industrial workers from both occupational and general health hazards. It assists local health departments to develop their programs and services in industrial health and provides direct services (medical, engineering, and nursing consultations and studies) to individual industries. The bureau maintains a laboratory for the analysis of samples of materials used in industrial processes which may be hazardous to health.

DIVISION OF ENVIRONMENTAL SANITATION

The Division of Environmental Sanitation includes two bureaus, the Bureau of Sanitary Engineering and the Bureau of Food and Drugs.

Community water supply and sewage disposal in California are regulated through permits issued by the State Department of Public Health. In each case, action is based on investigations and reports made by the Bureau of Sanitary Engineering.

In order to reduce to a minimum the danger of water and insect-borne disease, the bureau maintains supervision of water supplies; sewage disposal systems; industrial waste disposal; beach, stream, and watershed pollution; mosquito control; and the handling of shell-fish. The work, which is primarily investigative, advisory, and promotional, is conducted through and with local health, water, and sewer departments. The bureau assists local authorities to safeguard the general sanitation of communities in emergency situations such as serious floods, earthquakes, fires, or other catastrophes.

A Section on Sanitary Inspections makes surveys of sanitary conditions, particularly related to the disposal of garbage and of sewage in areas where there are no community sewage disposal systems. This section conducts surveys throughout the State to ascertain the presence of disease in rodents, particularly plague, and assists local health officers in preventing the spread of rabies.

The Bureau of Food and Drugs is charged under California law with the responsibility for the detection and prevention of adulteration and mislabeling of foods and drugs produced within the State. The bureau coöperates with the Federal Food and Drug Administration in the control of products which cross State lines. Within the bureau is the section of Cannery Inspection which administers and enforces California laws governing the canning and packing of meat and nonacid fruit and vegetable products.

DIVISION OF LABORATORIES

The Division of Laboratories engages in six principal activities: diagnostic procedures involving bacteriologic and serologic examinations related to the control of communicable diseases; manufacture and distribution of biologic products and of one per cent silver nitrate outfits; analysis of food and drugs, required primarily for the enforcement of the laws relating to the purity of such products; analysis of water and sewage, for the purpose of insuring the safety of water supplies; and enforcement of laws that require licensing of manufacturers and distributors of biologic products, that regulate clinical and public health laboratories, and that require the licensing of laboratory technicians.

The Virus Laboratory examines specimens for the diagnosis of virus diseases such as encephalitis and, through a grant from the Rockefeller Foundation, conducts extensive research to determine the cause, epidemiology, and methods of controlling influenza.

Other research in the cause and control of communicable diseases and in methods of improving public health laboratory procedures is also conducted.

DIVISION OF LOCAL HEALTH SERVICE

The Division of Local Health Service promotes the establishment and development of full-time local health departments staffed with qualified public health personnel and conducting programs meeting the recommended standards of public health practice. The relationship of the division to local health departments and officials is advisory, except insofar as the bureau administers State and Federal funds made available to local health departments. By utilizing the professional personnel from the other divisions of the department, the Division of Local Health Service serves to coördinate the varied programs of the department.

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(Note.—Articles relating to the history of the California State Department of Public Health have appeared in the following issues of CALIFORNIA AND WESTERN MEDICINE: Editorial "A National Department of Public Health," February, 1937, page 74; "Historical Notes on Public Health in California," article by Guy P. Jones, Sacramento, October, 1937, page 250; Article, "The Platform of the American Medical Association," December, 1939, page 394; Editorial "Federal Department of Health Officially Proposed by Thomas M. Logan, M.D., of California in 1871," January, 1940, page 2; "National Department of Health Proposed in 1871: By Thomas M. Logan, M.D., of California," article by Walter M. Dickie, M.D., San Francisco, January, 1940, page 6; "Benjamin Franklin Keene, Founder of the California Medical Association," an article by Louise F. Hays, Atlanta, Georgia, May, 1942, page 297; Editorial "Thomas M. Logan, M.D., Co-Founder of California Medical Association; His Efforts in 1872 to have United States Establish a National Department of Health, With Its Chief in the President's Cabinet," July, 1945, page 2; "Thomas M. Logan, M.D., Organizer of California State Board of Health and a Co-Founder of the California Medical Association," article by Guy P. Jones, San Francisco, July, 1945, page 6; "Early Public Health in California," an article by Guy P. Jones, San Francisco, December, 1945, page 275.†)

Jan Swammerdam (1637-1680).—The outstanding work of Swammerdam is contained in his history of insects published in 1669. By his studies he confirmed the theory of Harvey that there is no self-generation of small insects. Swammerdam was an expert in microscopic dissection, and is given recognition for being the first to see and describe the red blood corpuscles. Most of his life was devoted to intensive efforts in minute anatomy and embryology.—Warner's *Calendar of Medical History.*

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† Addresses of Department of Public Health of the State of California follow:

San Francisco—668 Phelan Building, 760 Market Street, San Francisco 2; UNderhill 8700.

Sacramento—631 J Street.

Los Angeles—State Office Building, 217 West First Street; MAdison 1281.

Director, Wilton L. Halverson, 668 Phelan Building, 760 Market Street, San Francisco 2.

TYPHOID FEVER OUTBREAK TRACED TO CREAM FILLED PASTRIES*

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AND
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An outbreak of phage type E typhoid fever occurred during June and July, 1945, in southern Alameda County, California, involving twenty-one primary cases. The source of the infection was traced to cream filled pastries prepared and consumed at a local restaurant. An employee of the restaurant, a pastry cook, was identified as the carrier responsible for the outbreak. An interval of fifty-one days elapsed between the onset of the first case and the date when typhoid fever was first definitely diagnosed. Investigations were carried on jointly by the State Department of Public Health and the Alameda County Health Department.

HISTORY OF OUTBREAK

On July 25, the Bureau of Acute Communicable Diseases, State Department of Public Health, was notified by the Division of Laboratories that Eberthella typhi had been recovered from feces and/or blood of two persons residing in southern Alameda County. In the preliminary investigation of these cases, it was discovered that both had attended an anniversary dinner of the Pleasanton and Livermore societies, Chapters of the Native Daughters of the Golden West, held at a popular restaurant near Niles, Alameda County, on the night of June 28.

Further questioning disclosed the interesting information that of the thirty-four persons attending the dinner, nearly one-half had subsequently become ill. This fact was well known to many of the women attending the celebration, several of whom had already decided that the June 28 dinner was responsible for their common, undiagnosed malady. A number of the ill persons were receiving medical care at this time, but the correct clinical diagnosis had not yet been made.

With the etiological diagnosis definitely established in two individuals, other members of the group were visited and all persons with a history of recent, unexplained illness were required to submit specimens of feces and blood for laboratory examination. Bacillus typhosus, phage type E, was recovered from the feces or blood of fifteen of the thirty-four ladies who had attended the dinner. In this group of fifteen clinically ill persons there was one death with typhoid fever as the assigned primary cause.

The dates of onset were between July 3 and July 17. The prominent symptoms were fever, headache, abdominal pain, muscular aching, and diarrhea. The Widal test was usually positive and in three cases the organism was recovered by blood culture.

One secondary case has been reported. A four-year-old grandchild of one of the fifteen Native Daughter patients became ill following a visit to the home of her infected grandmother. The phage type of the recovered organism was type E.

EPIDEMIOLOGIC HISTORIES

Epidemiologic histories taken from all ill persons immediately confirmed the suspicion that the source of the infection was closely related to the June 28 anniversary celebration at the Niles restaurant. There was no other common association of the infected persons during the probable incubation period. Since it could reasonably be assumed that the gastrointestinal tract was the portal of entry of the organism, any substance ingested by the ill persons during the evening was suspect. Foodstuffs were, of course, a likely offender.

It was determined that no food or drink was consumed either before or after the dinner by any ill person which could have been accessible to other infected individuals. It seemed possible to conclude that the infection was acquired during the time the group assembled at the restaurant.

The menu consisted of soup, mixed green salad, fried chicken, potatoes, commercially canned string beans, coffee, rolls (no butter), fruit cobbler, ice cream, banana cream pie, and cake. Only three foodstuffs were uniformly eaten by all of the fifteen cases: chicken, potatoes, and banana cream pie. One of the three could be expected to be the vehicle. Fried chicken and potatoes could be ruled out presumptively because of the type of food, mode of preparation, and lack of opportunity for multiplication of the organisms.

Banana cream pie remained to be considered. Cream pastries are historical offenders, offering good cultural media, often in combination with ideal conditions for incubation and multiplication of organisms. It seemed probable that the vehicle responsible for transmitting the infecting dose of E. typhi was the banana cream pie.

When it became apparent that the infection was acquired at the restaurant, all food handling personnel were required to submit specimens of feces, urine, and blood for examination. The history of each was also obtained. Phage type E typhoid bacilli were recovered from the feces of two employees: a waitress, J. L., and the pastry cook, E. G.

REPORT OF CASES

Case 1.—J. L., who was employed as a part-time waitress, had the habit of sampling what she served, especially pie and cake. Her onset with phage type E typhoid fever was on July 3. She continued to work as a waitress until July 15, when a 104-degree fever forced her to bed. No history of a previous enteric illness could be obtained.

* * *

Carrier 1.—When questioned, E. G., the pastry cook, was not ill. He readily admitted hospitalization for a febrile illness diagnosed by a physician as typhoid fever, in Des Moines, Iowa, in 1921. After a satisfactory clinical recovery and on the advice of his physician, he did not return to his regular occupation as a baker until one year later. Upon his return to work, he continued his occupation as a baker in Des Moines, Iowa; Kansas City, Missouri, and finally California. During his eight years of California residence, he was employed as a baker and pastry cook at prominent hotels in San Francisco, Berkeley, Sacramento, Richmond, Del Monte, and Palm Springs. In this period, many Californians consumed his specialties. His estimate: one million customers in eight years.

On February 26, 1945, E. G. accepted the position of pastry cook at the Niles restaurant. He rapidly built a reputation for his pastry specialties which extended into several surrounding counties.

COMMENT

Pies were one of E. G.'s specialties. One San Francisco patron had enjoyed them on twenty-six consecutive Sundays. On June 28, E. G. prepared ten to twelve banana cream pies according to his standard formula. Pie dough was prepared by hand and shell-baked until brown. The filling consisted of a standard commercially packaged vanilla cream pudding powder, plus eggs, which were added to a quantity of milk and heated in a double boiler for ten minutes. The filling was then placed in a large pan to cool.

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* From the office of the Bureau of Acute Communicable Diseases of the California State Department of Public Health, San Francisco, and the office of the Health Officer of Alameda County, Oakland, California.
Submitted for publication, December 15, 1945.

Bananas were peeled and sliced by hand into each pie shell. The cream filling, now nearly cool, was added, and the pies were then allowed to stand for an hour at room temperature for further cooling. Final touches consisted of applying meringue frosting (pre-cooled egg whites beaten stiff) and browning the pies in a 450 degree oven for five minutes. On June 28, the pies were finished between 1:00 and 1:30 p.m. and placed in a storage case (temperature 82 to 84 degrees) until serving time at about 6:00 p.m.

Pies were often cut by E. G. himself. This operation consisted of dipping the cutting knife in a can of hot water between each slicing maneuver to aid in cutting the meringue smoothly. Any frosting which clung to the knife was removed by pulling the blade between thumb and forefinger.

In our discussion with E. G., it was learned that of the ten or twelve banana cream pies prepared on June 28, only an estimated seven were served to the Native Daughters. The remainder were presumably eaten by the restaurant's regular clientele. This required an answer to the question which immediately posed itself: who had consumed the remaining pies which had been prepared at the same time, using common ingredients and identical technique? Other cases of typhoid fever outside the Native Daughters group would logically be expected to occur. None had been reported.

The management was unable to supply the names of persons who might have dined at the restaurant on June 28, with the exception of one small group, which was subsequently found to have escaped infection. During the examination of the restaurant's food handlers, it was deemed advisable to recommend temporary closure of the restaurant. This request was acceded to without delay. Health officers in surrounding counties were advised of the possibility of missed cases of typhoid fever occurring in their jurisdictions. Since no other way could be found to warn those who had eaten at the restaurant during the suspect period, a carefully prepared news release was given to newspapers of general circulation, advising immediate medical consultation in the event of unexplained, febrile illness.

OTHER CASES

Six additional primary cases of typhoid fever, phage type E, have subsequently been diagnosed (the last on September 2), all of whom admitted eating at the restaurant between May 20 and July 6.

(1) A. M. ate at the restaurant on May 20. Her onset with phage type E typhoid fever was June 4. (2) B. C. visited the restaurant on several occasions between June 26 and July 3, eating banana cream pie and cake; onset: July 15. (3) M. D. stopped in for a cream puff on June 29; onset: July 14.. (4) L. B. recalled eating banana cream pie at a private celebration at the restaurant on June 29; his onset: July 11. (5) D. J. attended the restaurant with a party of eight on July 6. Two, including D. J., ate banana cream pie. D. J.'s companion had been vaccinated against typhoid fever in 1943. D. J. had not. His onset: July 13. (6) The infection in J. L., the waitress, has been discussed.

DISCUSSION

Mode of infection.—Epidemiologic investigation singled out the restaurant with certainty as the place of infection of the fifteen Native Daughters. Members were drawn from several communities and uniformly denied all other common association of the group during the preceding two months. Consideration was given to the possibility that the infecting dose of E. typhi might have been contained in some foodstuff brought to the restaurant by one of the group to augment the menu, such as butter. With the exception of the birthday cake, none was discovered. The cake was easily eliminated since several of the infected Native Daughters and all of the cases outside of this group had not eaten it.

Each of the foodstuffs consumed at the dinner excepting the banana cream pie could be discounted as the possible source of infection, either because it had not been consumed uniformly by all ill persons or because it constituted an unlikely vehicle as to chance of contamination and suitability for multiplication of the organism (fried chicken, potatoes).

It seems probable that the filling of the banana cream pie and/or the bananas (during the slicing procedure) were contaminated by the fingers of E. G., the pastry cook. After the filling mixture was heated, it was partially cooled and turned several times by hand. Bananas were sliced, also by hand, into the pie shells. Filled pies stood at room temperature or slightly above for a period of five to six hours before serving. The five-minute browning of the frosting certainly did not produce lethal temperature for the rapidly multiplying organisms.

That the infecting food was heavily contaminated is attested to by the short incubation periods (three cases had onsets within five days, eleven cases within seven).

Initial investigations of the restaurant disclosed a single toilet for use of the kitchen personnel, located in the building's second story. Inadequate handwashing facilities were noted. Subsequent information disclosed that a second toilet was located in close proximity to the kitchen, containing no handwashing facilities of any nature. Information as to the existence of this toilet had been withheld.

Considering his occupation, why had not E. G. been responsible for other known outbreaks between 1921 and 1945? It is, of course, possible that he may have infected an occasional individual and yet escaped detection as a carrier. Our study bears out this possibility, since the twenty-one primary cases included in this investigation were apparently not all infected on the same date.

Contact with E. G. convinced us that he was a methodical and fastidious person. (Among other things, he kept a diary of all important events.) We were inclined to believe his statement that he was careful in his toilet habits and that the soiling of his fingers may have been a very unusual occurrence.

It is possible, though not yet proved, that he may be an intermittent shedder of E. typhi. No blood, stool, or urine examinations were made prior to July, 1945.

If it could be accepted that the soiling of his fingers with feces was a rare occurrence, that his handwashing technique was ordinarily adequate, and if it could be proved that he is an intermittent shedder of E. typhi, it would then seem that the chance, statistically, for the simultaneous occurrence of organisms in his stool, soiled fingers, unwashed fingers, and contact with a suitable cultural media might be sufficiently remote to explain what appears to be a remarkable run of good luck.

A second explanation for the apparent lack of previous outbreaks of typhoid fever attributable to E. G. should be mentioned. An undiagnosed illness in E. G., in February, 1945, could conceivably have been clinical typhoid fever, or, if an incidental illness, it may have activated a latent gall-bladder infection with resultant shedding of large numbers of organisms. Since acquired immunity of permanent duration usually follows recovery, an attempt was made to verify his original 1921 diagnosis. This was unsuccessful, since all records in the Des Moines, Iowa, institution where he was hospitalized were destroyed by flood, and we were unable to determine whether the clinical diagnosis of typhoid fever was verified by laboratory methods. E. typhi have regularly been recovered from E. G.'s stools on three occasions between

July 30 and October 1, which is of interest in determining his status as an intermittent shedder. Widal reactions have been positive in higher dilutions than would usually be expected in a carrier. This, however, may be explained on the basis of an anamestic reaction.

Index of suspicion.—In the southern Alameda County outbreak, twenty-one reported cases of typhoid fever occurred with dates of onset between May 20 and July 17. Twenty-one cases had onsets between July 3 and July 17. Eighteen of this latter group lived within a radius of ten miles. The symptoms were only moderately severe in many patients, although of sufficient intensity to hospitalize ten persons. The dramatic decline of typhoid fever as a major cause of illness in the last fifty years has made the infection difficult to diagnose usually because it is not suspected.

Phage typing of Eberthella typhi.—Phage typing has received considerable discussion in recent literature.[1,2] Specific types A, C, E, F, J, L, and M of E. typhi are now recognized. Typing procedures were begun by the Division of Laboratories, State Department of Public Health, in July, 1943, and are now routine. Through June, 1945, six hundred and four blood, stool, and urine cultures, from three hundred and twenty-six individuals, positive for E. typhi, have been phage typed. Such a laboratory device lends itself admirably to the study of an outbreak of typhoid fever in the field, as was amply demonstrated in the 1944 epidemic (type C), in which the source of infection of eighty-four cases was traced to uncured cheese manufactured from raw milk. It was very helpful in studying the twenty-one cases discussed in this paper.

It is obvious that this procedure is of great assistance to anyone interested in studying the possible causal relationships between any two or more persons in whom E. typhi can be demonstrated.

FOOD HANDLERS' EXAMINATIONS

Following the typhoid fever outbreak discussed in this paper, the restaurant concerned has requested some type of routine examination of its foodhandling personnel. We believe that public health experience over the past fifty years has amply demonstrated that the usual type of infrequent medical and laboratory examination of food handlers will not prevent occurrences similar to the southern Alameda County outbreak. It is true that routine laboratory examinations of stool and urine will occasionally detect E. typhi in an apparently well person (food handler or otherwise), but the net effect of such a program when applied to food handlers is to give the public a false sense of security. Only a thorough history and physical examination, complete with appropriate laboratory tests repeated almost daily, could offer any reasonable guarantee against missing inapparent infections. Such a program is not feasible administratively, because of cost and lack of competent examining personnel.

The present trend in public health practice is to replace the unsatisfactory system of periodic medical and laboratory examination of food handlers with health department sponsored training courses in methods of modern restaurant sanitation. Such a course includes a discussion of habits of personal cleanliness.

CONCLUSIONS

1. Twenty-one cases of phage type E typhoid fever occurred in southern Alameda County, which were traced to contaminated cream-filled pastries. A carrier was identified.
2. The mode of infection is discussed.
3. Typhoid fever is no longer a common disease and for this reason is occasionally misdiagnosed. It should be considered in any unexplained febrile illness.
4. Phage typing of Eberthella typhi is a valuable epidemiologic tool.

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576 Callan Avenue, San Leandro.

REFERENCES

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CORNEAL TRANSPLANTATION*

REPORT OF CASE

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INTRODUCTION.—Inasmuch as the literature on this subject has been reviewed exhaustively by Castroviejo in a recent paper, a further review in this discussion would be superfluous. The essence of this presentation will be found in the colored motion picture illustrations. This paper is a case report illustrated by a motion picture in color, concerning a patient with keratoconus in which corneal transplantation was done by the Castroviejo method.

REPORT OF CASE

Mrs. L. L., a 35-year-old white housewife, was first seen on February 3, 1944, with the complaint that for the previous two weeks she had been unable to see anything but light from either eye. She gave a history of having had conical cornea for many years. She had never been able to wear a contact lens in the left eye, but had worn one in the right eye with comfort. At the time this patient was first seen, her uncorrected vision was light perception in each eye. With a contact lens, she could read 20/70 in the right eye and 20/100 in the left. In the right eye there was a very large cone with many opacities in the posterior surface and the cornea was about one-third of the normal thickness. The left eye presented a similar picture except that the stroma over the cone was quite hazy and Descemet's membrane was bulging in the center where there was a staining area about two millimeters in diameter, characteristic of a vesicular keratitis.

Immediate treatment consisted in application of a pressure bandage and atropine. Seven days later, the cone was much flatter and the eye was much less irritated. The patient was very much discouraged and felt that life was not worth living under these conditions, inasmuch as she could hardly get around her own home and was unable to take care of her children.

She was advised to have a corneal transplantation. When suitable material could be obtained, a transplant was done by the Castroviejo technique; recovery was uneventful except that there was a small anterior synechiae in the lower outer corner of the transplant. This has caused no serious damage and no vessels grew into the transplant. During the first postoperative month, 400 R units of unfiltered x-ray were given. This transplant has remained quite clear to date. Two months after surgery, the vision in this eye was 20/30. With a small cylinder and a plus 3 sphere, the vision could be improved to 20/20.

The patient was so pleased with the result that she insisted upon having the other eye done. A corneal transplant, by the same technique, was done on November 9, 1944, and the pictures to be seen are those taken at that operation. One month after operation, the vision in this eye was 20/50 plus, uncorrected, and 20/30 corrected. No vessels have grown in, and the corneal transplant has remained quite clear.

INDICATIONS FOR CORNEAL TRANSPLANTATION

Determination of the indications for corneal transplantation in cases of conical cornea is important. These may be listed as follows:

1. When the tip of the cone begins to break down

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* Read before the Section on Eye, Ear, Nose and Throat, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

and a Descemetocele is formed, then corneal transplantation becomes mandatory.

2. When a patient is unable to wear a contact lens for a practical amount of time.

3. When the tip of the cone becomes so opaque that vision is not good even with a contact lens.

The advisability of doing transplantation in the presence of one good eye is always debatable. However, in threatened rupture this is mandatory.

OPERATIVE COMPLICATIONS

Complications may be divided conveniently into those occurring in the immediate postoperative period, and those occurring in the late postoperative period.

In the first instance, namely the complications occurring in the early postoperative period, that most to be feared is incarceration or prolapse of the iris. This particular complication is very prone to occur in those cases having transplantation for conical cornea, inasmuch as a very large section of the cornea is transplanted. The iris is in very close proximity to the wound and it is easily incarcerated. This complication is a difficult one to treat, inasmuch as manipulation during the immediate postoperative period nearly always leads to a cloudy segment. It is better perhaps to leave these alone unless there is a frank prolapse, and to make a secondary repair at a later date. It is to be noted that in cases in which incarceration occurs, it is doubly necessary to use x-ray following hospitalization in order to prevent vascularization of the transplant. Although in the past infection has been a complication to be feared, under modern conditions this is no longer so important.

In the late postoperative period the common complications are opacification of the transplant and vascularization. For the former there is little to be done, but in the latter x-ray is very helpful. It has been my custom to use approximately 400 R in divided doses of 50 R each. Doses can be given about five days apart. Consoling to the surgeon is the fact that if opacification of the transplant occurs, a retransplant can always be done. It is necessary, however, that the new transplant exceed the old one in size.

GENERAL POSTOPERATIVE COURSE

It has been my practice to leave sutures in for at least ten days. Some have argued that the sutures might damage the new corneal epithelium, but I have not found this complication in any of my cases.

As has been noted in the motion picture it has been your speaker's custom to place an air bubble in the anterior chamber at the time of operation. This indicates clearly whether the transplant fits properly and acts as a cushion for pressure changes, and this should help to avoid the complication of iris incarceration.

Your speaker generally sends his patients home in two weeks and they wear a pressure bandage for about a week longer; and are under atropinization for approximately a month.

COMMENT

It is necessary that the technique of corneal transplantation in cases with conical cornea be particularly scrupulous, inasmuch as the cornea is so thin. Such thinness adds very considerably to the difficulties of cutting the cornea accurately. When the marking knife is used the cornea has a tendency to buckle and when the scissors are used a clean cut is difficult to make. In the operation done for corneal leucoma in which the cornea is of normal or greater than normal thickness, the procedure is relatively easy. Furthermore, in the conical cornea cases a large transplant is necessary in order that it may act as a support for the remaining portion of the cornea. The contrary is true in the corneal leucoma cases in which the cornea itself acts as a support for the transplant.

Following transplantation the question of the amount of astigmatism produced arises. In general, astigmatism is about of the same order as that found after cataract surgery, although in those cases that develop anterior synechiae the amount may be greater than normal, and at an odd axis.

It behooves opthalmologists on the Pacific Coast to familiarize themselves with this type of procedure and to make use of it. There will probably be a great number of patients with corneal leucoma coming back from the armed services, who will require corneal transplantation. Too, there are those with conical cornea who have threatened rupture, or who are unable to wear contact lenses, who should be given the privilege of having this type of surgery.

SUMMARY

A colored motion picture was demonstrated to show the technique of corneal transplantation in keratoconus by the Castroviejo technique. A discussion of some of the complications was presented. Colleagues were urged to make the use of this type of surgery more widespread.

727 West Seventh Street.

DEAFNESS—A MODERN APPROACH TO ITS TREATMENT

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It might be said that in no other field of medicine more pessimism and "defeatism" is to be encountered than that which exists with regard to the treatment of deafness. The following pronouncements are examples of authentic statements by so-called authorities in the field of otology:

"Nothing can be done for deafness."

"The patient has nerve deafness, so there is no treatment."

"Your child is congenitally deafened and there is nothing that can be done. When he will be 5 or 6 years old, institutionalize him in a school for the deafened."

"We do not operate because of deafness."

"I can arrive at a diagnosis of deafness and tell whether my patients are improving without an audiogram."

ERRONEOUS STATEMENTS MAKE FOR PESSIMISTIC APPROACH

Fortunately, not one of these statements is true. But the disturbing fact remains that physicians in general and otologists in particular are so easily prepared to accept defeat in the treatment of deafness. Not even in the care and treatment of cancer patients has a comparable attitude of pessimism been allowed to become established almost without a challenge. But while cancer is notably a disease of old age, usually found in persons who have passed the prime of their active life, deafness is most harmful in childhood and youth. Moreover, the number of persons suffering from deafness is much larger than the number of cancer patients. It would, therefore, be no more than a socially and economically logical procedure to institute the most comprehensive research for the study and treatment of deafness. There is a great need for a few heavily endowed institutions with the sole purpose of furthering the research and advancing the clinical treatment of deafness. Such research centers would undoubtedly attract the keenest minds in otology. It might even be possible to popularize the fight against deafness and to institute for this purpose another "March of Dimes."

REHABILITATION OF THE DEAFENED

The fact that deafness is not a deadly disease should be recognized as a good reason for the salvage and repair of persons with hearing defects. The deafened can find gainful employment more easily than the blind, but they fit themselves less smoothly into a normal social environment than those handicapped by other crippling diseases and infirmities. The rehabilitation of the deafened must be considered as a medical and social challenge of utmost importance; and only ignorance of the possibilities of social readjustment can lead to the misapprehension that institutions for the deaf are established for the purpose of ridding families of their handicapped and problematic members.

The observation has often been made that blind persons are, as a rule, of a happy and cheerful disposition. They frequently are vivacious and enthusiastic people of excellent social adjustment. Deafened persons, on the other hand, are not likely to present a similarly genial personality, unless they have received all possible medical treatment as well as guidance towards rehabilitation. Otherwise deafness will prove to be injurious and even ruinous to disposition and character, especially if the impairment begins in early life or develops to severe proportions. It takes a strong character indeed to overcome the trauma of deafness.

It has been the experience of the medical staff of the Armed Forces that the initial attitude of newly deafened patients is unfailingly negative. At first they will be downhearted and morose, profoundly hopeless, and completely uncoöperative. In almost every case it proved difficult to overcome the emotional barrier; yet only in this manner was it possible to guide the disabled veteran towards renewed participation in a normal life.

If a deafened child is to grow into adulthood without developing a marked inferiority complex accompanied by compensatory and reactive mechanisms, great intelligence, patience and the willingness to undergo special education will also be required on the part of the parents.

INFANTS AND YOUNG CHILDREN PRESENT DIAGNOSTIC DIFFICULTIES

It is most difficult to arrive at a diagnosis of deafness in an infant, or in a child under 4 or 5 years of age. If the child is totally or severely deafened, the parents may note that it sleeps in spite of loud noises in its immediate vicinity, or that it fails to respond when spoken to. But generally deafness will be suspected only if the child does not learn to talk, or articulates with a pronounced speech defect. As it is unable to hear, it is equally incapable of reproducing sounds correctly. All too frequently such children are judged by lay people and even diagnosed by physicians as mentally defectives. Institutions for the feeble-minded contain many children whose only defect is a hearing deficiency.

REPORT OF CASE

Case 1.—When I began my first year of teaching in public schools, my fellow teachers made it a point to advise me not to waste my time trying to teach little Jerry anything. They were unanimous in their judgment that Jerry was mentally defective and that he should be seated at the back of the class, and kept out of the way. After a month of sincere efforts to teach Jerry, I finally agreed with my fellow teachers. For the rest of the year Jerry sat at the back of the room and was again ignored. Needless to say, this boy had already developed into a social misfit with a distorted personality. His knowledge was inferior to that of the other children. Even his family agreed that Jerry was "dumb" and suggested not to waste too much attention on him. But when two years later routine hearing tests were given to the children of that school, poor Jerry was found to have struggled along under the handicap of a severe hearing deficiency. By that time, however, the feeling of inferiority had caused him to become a problem child.

COMMENT

Only a few weeks ago, a blind young lady of about 30 years of age came to my office for the treatment of a mild sinus infection. She was accompanied by her "seeing eye" dog. Everyone knows what an impressive sight such a pair make. Any blind person will attract attention and evoke pity and consideration. This young patient told me how valiantly her eye doctors had worked for months, trying to save her sight. Seven nationally and internationally famous eye specialists had been called into consultation on her case at the great eye clinic of the Presbyterian Medical Center in New York City. As an otologist it occurred to me that I have never witnessed an effort of comparable determination made in order to save a person's hearing.

Often it might almost seem as if the otologist would only begin to feel concerned about an ear disease, when the infection threatens to become fatal. In fact, a prominent otologist visiting Los Angeles a year or two ago made the remark which has already been quoted at the beginning of this article: "We do not operate because of deafness."

Any physician graduating from Medical School has but a limited understanding of the ear and the deafened patient. Unless he specializes in the field of otology, he is unlikely to learn much more on the subject; in fact, as time goes on he forgets part of his earlier knowledge. And even the otologist in his specialized training often learns little about deafness and the specific problems of the deafened as the emphasis placed upon the various problems is largely dependent on the interests of his teachers. Therefore, it is not surprising that, as a rule, otolaryngologists seem to find other branches of their specialty more interesting and otherwise attractive.

RECENT PREVENTIVE AND THERAPEUTIC MEASURES

Yet, in the last few years, an almost revolutionary change has taken place in the prevention and treatment of deafness. Dr. Julius Lempert has developed for the welfare of humanity one of the greatest, if not the greatest surgical interventions of the century giving the otosclerotic deafened improved hearing through the fenestration operation. But medical progress has also produced other methods designed to alleviate the sufferings of the deafened. It may, therefore, be useful to enumerate the various procedures which can find application in the treatment of deafness.

AN ENUMERATION OF POSSIBLE PROCEDURES

1. Nose drops—for the treatment of sinus infection, nasopharyngitis or inflammation and swelling of the eustachian tubes.
2. Sulfa drugs and penicillin (systemic)—for the systemic diseases which may cause deafness.
3. Tonsillectomy and adenoidectomy—especially adenoidectomy for the removal of adenoid tissue from the openings of the eustachian tubes.
4. Repeated adenoidectomy if indicated.
5. X-ray or radium treatment of the adenoid tissue blocking the entrance to the eustachian tubes.
6. External care for draining ears—dry wipes, swishes, aspirations and ear drops (sulfa drugs or penicillin).
7. Simple mastoidectomy.
8. Radical mastoidectomy.
9. Fenestration operation of Lempert, in case of otosclerosis.

10. Care and recommendations relative to general health—diet, environment, rest, etc.

11. Vitamins—especially vitamin B complex (but vitamins only if a vitamin deficiency exists. A well-balanced diet is preferable to synthetic vitamins).

12. Endocrine studies with special endocrine treatments if indicated.

13. Diagnosis of allergy and treatment if indicated.

14. Thorough checkup for foci of infection and their removal if found. In order of importance and frequency the foci of infection rank as follows: 1. Teeth; 2. Tonsils; 3. Sinus; 4. Miscellaneous (gall bladder, prostate).

15. Removal of noise trauma — noise whether high pitched, low pitched or mixed causes a high-toned, permanent nerve deafness.

16. Removal of any exogenous toxins, such as chemicals or other poisons at place of employment.

17. Removal of certain drugs that may cause deafness, such as quinine, salicylates.

18. Blood studies for syphilis, and treatment if indicated.

19. Diagnosis concerning intra-cranial tumors, and advice relative to surgery or treatment.

20. Establishment of possible malingering, and proper "treatment."

21. Determination of possible presence of hysteria, and proper "treatment."

22. Diagnosis of possible labyrinthitis (including Ménière's Syndrome) and treatment as indicated.

23. Explanation of handicaps of deafness to patient, parents, teachers and other associates, thus creating understanding, consideration and sympathy towards patient's possible abnormal reactions.

24. Discussion with patient, family and associates of abnormal social, psychologic and economic aspects of deafness.

25. Advice to deafened person to sit at the front of a school room or auditorium with the better ear towards the speaker.

26. Prescription of a hearing aid if necessary. The vacuum tube hearing aid is almost always preferable; bone conduction hearing aids should be prescribed only in rare instances.

27. Recommendation to study speech reading in a school for the deafened and to join a league for the hard-of-hearing.

28. Sustained and sympathetic interest in the patient's case, with due consideration of the psychological aspects of deafness and the depressing and introverting consequences of a hopelessly negative prognosis.

29. Advice and guidance of the patient relative to rehabilitation. Training schools are now being established, chiefly by the government for returning war veterans to teach them new and appropriate trades and skills.

30. Advice to the parents to beware of quacks.

31. Instruction to the patient and his relatives about the necessity of regular audiometric check-ups.

32 Routine audiometric hearing tests should be given each new patient seen by the otolaryngologist. Only in this way can early and obscure hearing losses be detected No examination of the ear, nose and throat is thorough or complete without an audiogram.

IN CONCLUSION

The choice of treatments and procedures from which the patient is likely to derive the greatest benefit will depend upon the characteristic features of each individual case. But the fact that such a large selection of methods has been evolved should dispel any notion that nothing can be done for deafness.

65 North Madison Avenue.

CONGENITAL ATRESIA OF THE ESOPHAGUS WITH TRACHEO-ESOPHAGEAL FISTULA*

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and
Lieutenant Robert C. Hickey (MC), U.S.N.R.
San Diego

THE purpose of this communication is to review and further direct attention toward an anomaly of the gastro-intestinal tract, congenital atresia of the esophagus with tracheo-esophageal fistula. It is our wish to demonstrate the antemortum diagnostic roentgenographic findings and to show roentgenographically the pathologic anatomy as seen at necropsy.

Congenital artesia of the esophagus with tracheo-esophageal fistula is not a new entity, having been described in 1670, but it is an entity in which there has been a revived interest and a definite hope for cure with the advent of the present day scope of thoracic surgery and the newer chemotheraputic methods. This malformation produces a syndrome which involves both the digestive and respiratory systems, and in which, without intervention, the outcome is death. In this presentation, therapeutic triumphs cannot be stressed.

CLINICAL MATERIAL

In twenty months with 3,630 unselected deliveries, we have had two cases in full term, apparently normal, healthy infants following a normal pregnancy and delivery at a U. S. Naval Hospital dependent service. Brenneman[1] states that in his experience it is the most frequent congenital anomaly of the gastro-intestinal tract with the possible exception of hyperplastic stenosis of the pylorus, and Vogt[2] estimates approximately two cases in eight hundred and fifty infant hospital admissions. The statistics as regards frequency of congenital atresia of the esophagus vary widely. The reported cases number about four hundred, but undoubtedly more occur than are recognized.

DEVELOPMENT

In the development of the esophagus, the lower portion forms from the pregastric segment of the foregut. A more cephalic portion of the foregut gives rise to the upper esophagus and the entire epithelial mold of the respiratory tract. The tracheo-bronchial rudiment cleaves from the upper esophagus by means of two longitudinal lateral infoldings. With the approximation of the infoldings, the respiratory tract is formed and continues to develop and branch at its free end. This separation occurs early and is present by the end of two lunar months. The diverse malformations of the esophagus actually have a wide range running from entire involvement of the passage to regional involvement, and from agenesis to doubling. With particular reference to congenital esophageal atresias, Vogt classified them into three main groups and subdivided the third group into three subgroups. Vogt's Type 1 is the very rare complete esophageal absence. Type 2 is where both the upper and lower esophageal segments end blindly, and Type 3 is where an esophageal communication, or fistula, with the respiratory tract exists. In Type 3a the upper esophageal segment communicates with the trachea or a bronchus.

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In Type 3b the lower esophageal segment communicates, and in Type 3c both esophageal segments have a communication with the tracheo-bronchial tree. Our cases were of the Type 3b, where the lower esophageal segment connects with the respiratory passages. This is the common type, and the one to be suspected until proven otherwise.

Why these esophageal malformations occur is a matter of conjecture. An incorrect cleavage of the longitudinal infoldings has been used frequently as a descriptive aid in understanding congenital esophageal atresia with or without fistula. This fits well with Vogt's classification. Various etiologic factors have been proposed such as intrauterine trauma, infection, extraneous pressures and others, which while applicable in one instance, fail when all possible lesions are considered, and so must be discarded. The proposal of a primary deficiency in the developmental capacities of the tissues concerned (Rosenthal,[3] Strong and Cummins[4]) is applicable and plausible. It is this theory with which we are in accord.

The clinical diagnosis of esophageal atresia with a tracheal fistula is rather stereotyped. There is a direct reflection of the anatomic problem involved with a dysfunction of the two systems, the respiratory and the digestive, being apparent. Soon after birth, attention is drawn to the respiratory system by the attacks of coughing, dyspnea, and cyanosis; then to the digestive tract when the infant fails to nurse normally, regurgitating his feedings, and drools and froths saliva persistently. Upon attempting to pass a soft rubber catheter an obstruction is met at about 12 cm. whereas the known distance to the stomach from the lips in an infant is approximately 17 cm. The course is, as stated, one of progressive dehydration, inanition, and bronchopneumonia which without operative intervention leads to death usually within a week. Our cases followed the usual course. Surgical intervention had been advised against because of the poor surgical risk of each infant at the time of consultation. The infants died on the fifth and fourth days.

ROENTGENOGRAMS

The typical antemortum roentgenograms are shown in Figures 1 and 2. Upon introducing a radio-opaque medium into the upper segment, the upper esophageal portion is outlined in atresia as a blind sac. Iodized oil is preferred to barium in this study to lessen the chance of a pneumonic process. Our first case is so shown in Figure 1. The presence of a tracheo-esophageal fistula is manifested by air within the stomach and the upper intestines. With a blind upper esophagus in a newborn, air could only be present here as the result of a communication by the lower esophageal segment with the respiratory passages. The clinical findings are those of a round, tympanitic, upper abdomen. The roentgenographic demonstration of air within the stomach and upper intestinal tract is shown in Figure 2. Figure 3 demonstrates the pathologic anatomy at necropsy as seen with the roentgenograms. Through the stomach into the esophageal phrenic ampulla, a tube was introduced, and a barium mixture injected. The barium outlined the lower esophageal segment, passed into the trachea through the fistula opening just above the carina, and then filled the tracheo bronchial passages. It can be further noted that a small amount of barium entered the upper esophageal segment by spilling over at the epiglottis. The superior and inferior portions of the upper esophageal segment have been indicated on the roentgenogram in Figure 3, as the segment reproduced somewhat indistinctly, being overshadowed in the lateral view by the soft tissue density of the infant's arms.

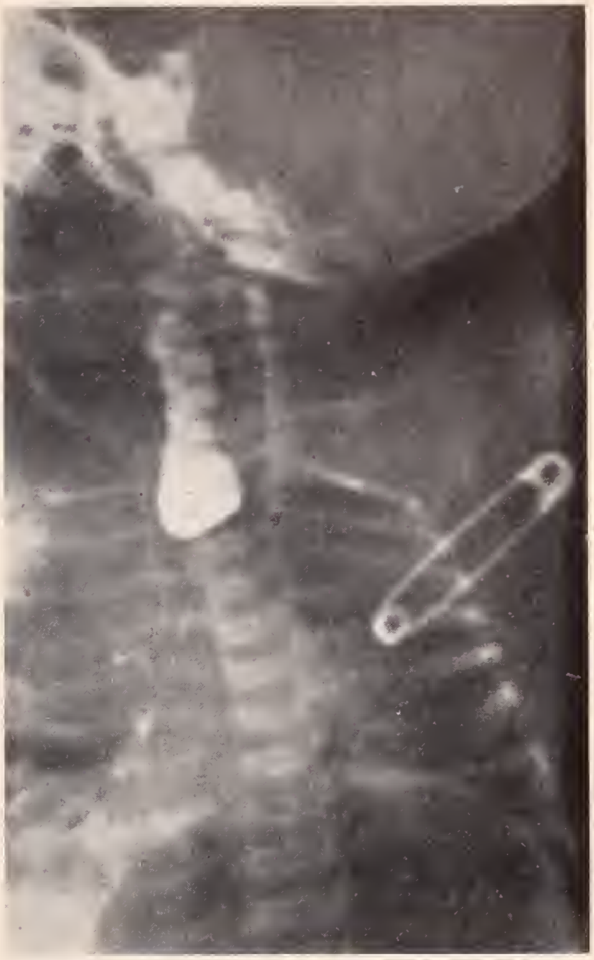

Fig. 1. Case 1.—The blind upper esophageal segment is outlined as a blind sac by a radio-opaque medium.

TREATMENT

The confronting therapeutic problem is twofold. The infant must be given a means of taking food and liquid, also aspiration pneumonia must be prevented. However, before and if treatment is undertaken, an appraisal must be made, especially for other congenital anomalies, often of serious importance. In 72 cases of esophageal atresia with or without fistula at the Children's Hospital in Boston, Ladd[5] reports 23 infants without accompanying malformations while in other infants, there were 63 anomalies associated with atresia of the esophagus. These in themselves may require major surgical procedures or may even be incompatible with life. A necropsy was not performed on our first case, but no other anomaly was detected clinically. The second infant had a cord-like descending portion and inferior portion of the duodenum in addition to the esophageal lesion. Although this was not an entirely complete atresia as evidenced by air within the jejunum and ileum in a roentgenogram, the probable outcome, even had a successful esophageal repair been done, is obvious.

The method of therapeutic attack is surgical with a direct and an indirect approach. The direct attack is a single stage extra-pleural ligation of the tracheo-esophageal fistula and a primary anastomosis of the esophageal segments. With the indirect method, the fistula is tied off and a gastrostomy and an esophagostomy done; later a skin tube, or anterior esophagus, is constructed connecting the upper esophageal segment and

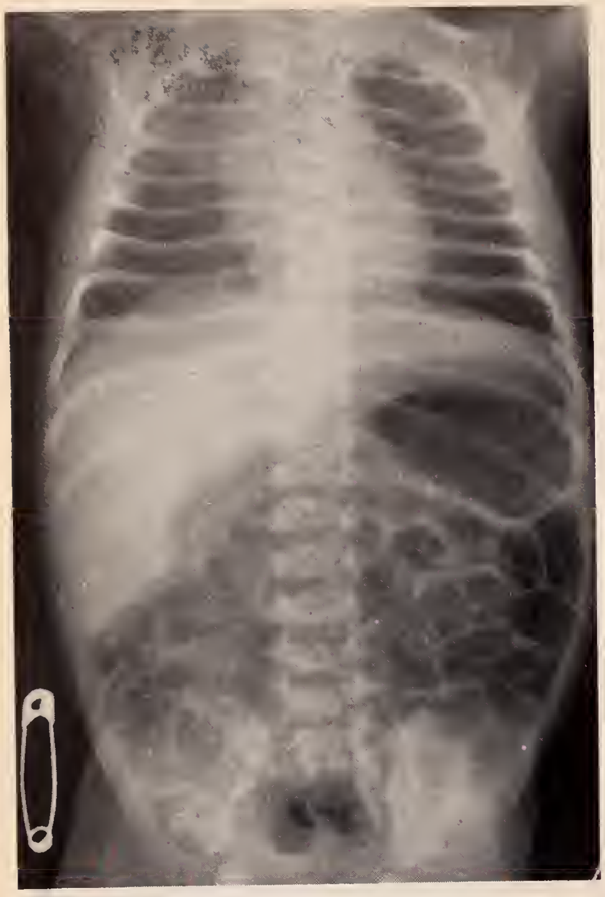

Fig. 2. Case 1.—Air within the upper intestinal tract is noted. In a newborn with a blind upper esophageal segment, air could be present thus only if an air passage communication existed. In Case 2 a similar roentgenogram was nearly identical.

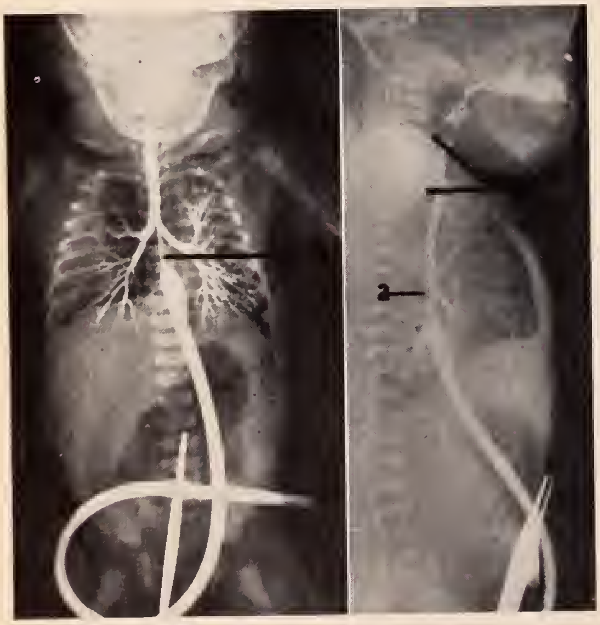

Fig. 3. Case 2.—The post-mortem roentgenographic findings are demonstrated. The upper (1) and lower (2) esophageal segments are indicated. See text. The soft tissue density of the arms partially obscures the upper segment in the lateral view.

the gastrostomy. Haight and Towsley[6] reported, in 1943, the first successful reconstruction by the direct method; the first child whose life was so salvaged was reported over three years old in 1944 (Haight[7]). Leven of St. Paul and Ladd of Boston each have a living patient about 18 months older in some stage of the indirect or multiple stage procedure.

COMMENT

Congenital atresia of the esophagus with tracheo-esophageal fistula is not a condition where striking, uniform, therapeutic successes are to be expected. The attending difficulties are multiple and great. However, Lam[8] reports from the literature, in 1945, 13 living of 36 patients operated upon by the direct method, and 15 living infants of 33 who are in some stage of the indirect method. Another writer, Vogt, in 1929, stated that if congenital esophageal atresia were as rare as it is fatal, we would be unable as yet to find the first recorded instance. The difference is momentous; in the span of a few years a new perspective has replaced that of a cold, hopeless outlook.

SUMMARY

A brief review to direct interest toward a not infrequent congenital anomaly has been presented. This is an anomaly in which there has been increasing interest and increased hope. Considerations as regards frequency, embryology, diagnosis, roentgen anatomy, and treatment have been discussed. Two cases from a U. S. Naval Hospital are included.

U. S. Naval Hospital.

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Marcello Malpighi (1628-1694).—To Marcello Malpighi goes the honor of having been among the first to apply the microscope to the study of animal and vegetable structure, and of being the founder of microscopic anatomy. He did extensive and valuable work on the anatomy of the silkworm and the morphology of plants. By his observations on the chick and its development he laid the foundation for the science of embryology. Though he described the red blood corpuscles in 1665, he was preceded in this by Swammerdam. He supplied a missing factor in Harvey's theory of the circulation of the blood from artery to vein.—Warner's *Calendar of Medical History.*

We owe gratitude to France, justice to England, good will to all, and subservience to none.

—Thomas Jefferson, *Writings.* Vol. ix, p. 420.

We must meet our duty and convince the world that we are just friends and brave enemies.

—Thomas Jefferson, *Writings.* Vol. xix, p. 156.

CALCIFIED TRUE ANEURISM OF LEFT RENAL ARTERY*

CAPTAIN J. P. BRADY (MC), U.S.N.
AND
COMMANDER J. S. HANTEN MC-V(S), U.S.N.R.
Mare Island

WHEN Mathe reviewed the literature in 1932 he collected 55 cases of aneurism of the renal artery, the first reported in 1719, and added one case of his own. Since that time nine cases have been reported from abroad, and seven in the United States. We wish to add one more.

REPORT OF CASE

C. B. L., age 52, whose only complaint was pain in the lumbar region, duration one month. It radiated anteriorally to the anterior superior spine, had not grown worse, was a severe ache in character, and had never been severe enough to necessitate narcotics. There were no urinary tract symptoms except nocturia one to two times, duration three months.

Past History:

Negative except for trauma in left lumbar region (kicked by a horse) 22 years before. At that time he had no hematuria, no symptoms except local soreness that did not prevent his doing his usual work.

Physical Examination:

White male 52 years of age, not acutely ill. Aside from being slightly undernourished, he appeared to be in good physical condition.

Pertinent Findings:

B. P. 160/100—peripheral arteries slightly palpable because of sclerosis.

Regional:

Neither kidney was palpable nor tender. No abdominal masses were found. External genitalia were normal. Rectal examination revealed a small normal prostate.

Results of Laboratory Studies:

1. E. K. G. Normal
2. R. B. C. 4,300,000. H. G. B. 90 per cent.
3. W. B. C. 8,300. Normal differential.
4 Kahn. Negative.
5. Urine. Specific gravity 1.015. Negative for sugar and albumin. Microscopic. 0 to 2 R. B. Cells. 4-6 W. B. Cells.
6. Sedimentation rate 30 mm. in one hour.
7. Blood sugar 89.2. Blood urea nitrogen 16.3 mgm.

Cystoscopy:

1. F. 24 B.B. cystoscope passed without difficulty. No residual urine.
2. No tumor, stone, nor ulceration seen.
3. Bladder capacity normal.
4. No trabeculation seen. No elevation of the bladder neck at 6 o'clock.
5. Prostatic urethra showed only slight congestion. No lateral lobe hypertrophy.
6. Right uretral orifice normal. Left uretral orifice showed slight edema without redness or ulceration.
7. F. 6 W.T. catheter passed without difficulty to each pelvis. No residual urine found. Specimens were negative except for a moderate number of W.B.C. from the left kidney.
8. Intravenous P.S.P. appeared within one and a half minutes.
9. Pyelograms were taken with ½ diluted neo-iopex.

Pyelograms:

Showed each kidney to be normal in size, shape, and position. No stones seen. Right was normal. Left revealed slight elongation and dilation of the upper calyx and an incomplete annular shadow situated near the hilus in the lower portion of the upper pole.

Diagnosis:

Three diagnoses were considered in the order of their probability and immediate surgery was advised because of the second.

1. Calcified cyst.
2. Early new growth with calcified cyst.
3. Aneurism, renal artery.

Treatment:

Nephrectomy was done in the usual manner; the operative findings being:

1. Kidney grossly normal.
2. An aneurism of the posterior branch of the renal artery.
3. Renal artery (portion included in pedicle tie) was very sclerotic. There was considerable difficulty in making the tie as the artery was so friable it leaked at the point the clamp was applied, with moderate loss of blood from brisk hemorrhage. Postoperative course was normal. The patient was given one transfusion of 500 cc. citrated blood.

PATHOLOGICAL EXAMINATION

U. S. Naval Medical School, Washington, D. C., 11 December, 1940.

Gross Examination:

Specimen consists of left kidney, measuring 12 x 7 x 4.5 centimeters. The capsule is slightly adherent. The surface is smooth and deeply congested throughout. On section the cortex is rather thin and the markings are obscured by a yellowish-white cloudy appearance. The pyramids are congested. The pelvis shows increased fat. Pelvic mucosa and ureter are congested. The renal artery is cut three centimeters from its entrance into the kidney and divides into two branches one anterior and one posterior branch near its beginning has formed two sacculated aneurisms—the first is elongated and measures 2 x 1.5 x 1 centimeter, the second one is oval and measure 2.5 centimeters in diameter. The connection between the two sacs is 0.5 centimeter in length and 0.5 centimeter in diameter. The smaller sac which lies anteriorly is empty but the posterior and larger is filled with an organized blood clot and has a shell-like wall which is partially calcified. The renal vein is not remarkable.

Microscopical Examination:

Section from the aneurysmal sac reveals a thickened hyalinized wall contining an atheromatous and calcified areas. Decalcification was necessary before sectioning. An old blood clot, without fibroblastic organization, is adherent to the intima. Sections from the kidney reveal a chronic inflammatory reaction with many collecting tubules filled with pus. There is interstitial fibrosis and invasion by many lymphocytes. The glomeruli are adequate in number and the tufts are large and congested. There is considerable cloudy swelling of the epithelium of the convulted tubules.

Pathological Diagnosis:

Aneurysm, arteriosclerotic—renal artery. Pyelonephritis.

/s/ O. WILDMAN,
Commander (MC), U. S. Navy.

* * *

DISCUSSION

The patient presented none of the signs of aneurism such as pain, swelling, pulsation or hematuria, except the first, and that in no proportion to the lesion.

Of the three causes of aneurism mentioned in the order of their incidence, trauma, arteriosclerosis and syphilis, this one was due to the second. Aneurism by x-ray may have two appearances, a more or less bizarre filling defect of the pelvis simulating papillary tumor (Loughnane) or the "wreath shadow" or "annular ring" mentioned by McKay, Mathe, Wesson, and Fulmer, McClelland and others.

We wish to call attention to the fact that while all calcified aneurisms may not present it, in our case, and the illustrations of the cases of Mathe, Renke, Wesson and Fulmer, McKay, McClelland and Child, there is a defect in the calcified ring, probably the connection between the aneurism and artery. This ring with a defect may be of value in the differential diagnosis of aneurism and other calcified masses. That it is spherical and hollow should differentiate it from calcified glands. Another fact that may be valuable in differentiating aneurism from cyst is that it is outside the parenchyma as demonstrated by stercoscopic plates (Fig. 1) although in the pyelograms it appears to be in the medial lower portion of the upper pole. (Fig. 2.)

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* Read before the Section on Urology at the Seventy-second Annual Session of the California Medical Association, Los Angeles, May 2-3, 1943.

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The authors wish to express their appreciation to Cismondi, E. L., Pharmacist Mate Second Class, U. S. Navy, for his excellent photography.

If aneurism is found, nephrectomy is indicated. We suggest that if aneurism is considered in the diagnosis that surgical measures such as an extra wide incision be made to facilitate exposure, as the sclerotic vessels may break on ligation.

It should be mentioned that this patient's hypertension did not improve after nephrectomy.

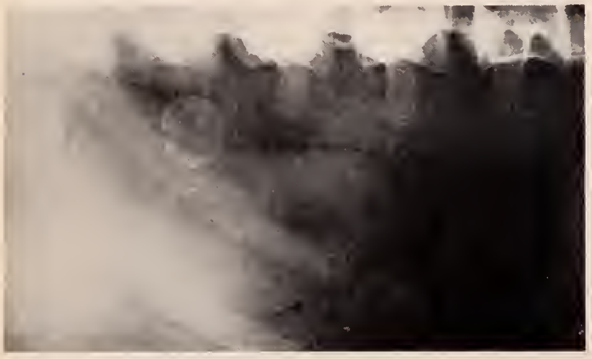

Fig. 1.—The renal shadow has been inked in to facilitate photography.

The position of the aneurism is not within the kidney substance.

Note the defect in the ring.

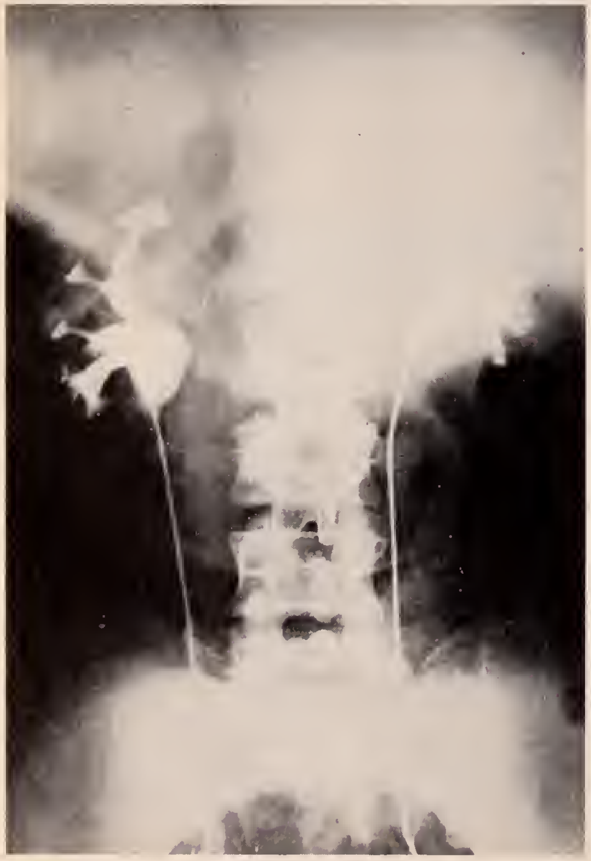

Fig. 2.—Pyelogram showing blunting and elongation of the upper calyx.

Note the incomplete ring shadow, and its relation to the pelvis.

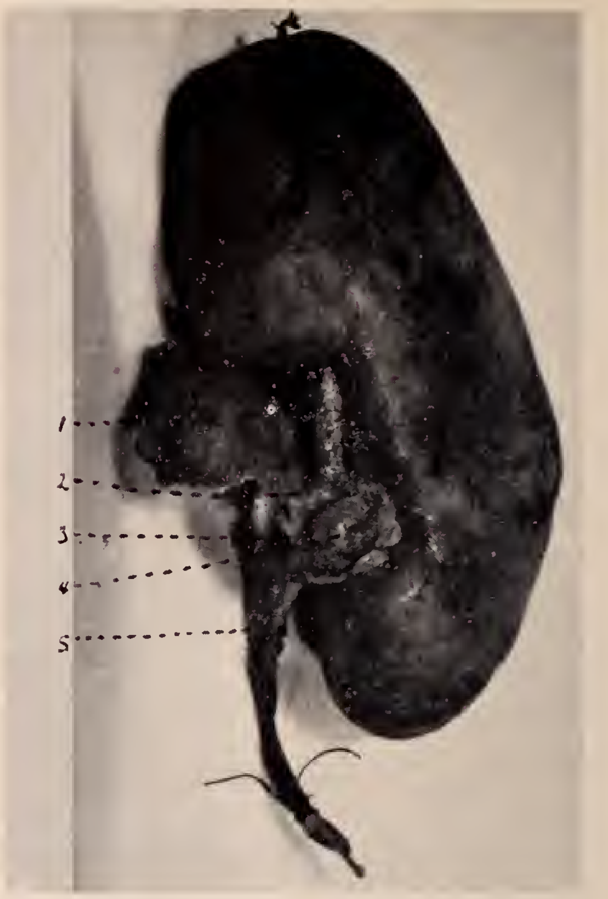

Fig. 3.—(1) the larger calcified aneurismal sac.

(2) Anterior portion of the renal artery with the superior and inferior divisions.

(3) The first portion of the posterior divisions of the renal A.

(4) Smaller aneurismal sac.

(5) Ureter.

SUMMARY

1. A case is reported of calcified aneurism of the left renal artery, due to arteriosclerosis.

2. Attention is again called to the broken-ring shadow that may be typical of calcified aneurism.

3. The hypertension did not improve after nephrectomy.

J. S. H., 700 C Street, Coronado.

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Frank Hinman, San Francisco
Albert J. Scholl, Los Angeles

Pharmacology:
W. C. Cutting, Menlo Park
Clinton H. Thienes, Los Angeles

75TH ANNUAL SESSION

California Medical Association

AT LOS ANGELES

Tuesday, May 7 - Friday, May 10, 1946

Make note of these dates on your Calendar.

Scientific Programs and Official Reports will appear in April issue of C. and W. M.

The official headquarters of the next annual session of the California Medical Association to be held at Los Angeles, Tuesday, May 7 through Friday noon, May 10, 1946, will be the *Hotel Biltmore,* 515 South Olive Street (Olive, between Fifth and Sixth Streets), Los Angeles. Because of postwar conditions and prospective attendance, the facilities of other hotels must also be used.

All requests for reservations must be sent to the hotels direct. In writing, it is well to state the number in the party, date of arrival, date of departure, nature of accommodations desired (single room, double room, double bed, twin beds, bath).

Los Angeles Hotels: With Telephone Numbers

A list of some hotels in Los Angeles within easy distance of the Hotel Biltmore follows:

Hotels	*Telephones*
Alexandria Hotel, 210 W. Fifth St.	(MAdison 2741)
Ambassador Hotel, 3400 Wilshire Blvd.	(DRexel 7011)
BILTMORE HOTEL, 515 S. Olive	(MIchigan 1011)
Carlton Hotel, 519 S. Figueroa St.	(MIchigan 6571)
Chapman Park Hotel, 516 S. Alexandria Ave.	(FItzroy 1181)
Clark Hotel, 426 S. Hill St.	(MIchigan 4121)
Gates Hotel, 831 W. Sixth St.	(TRinity 3931)
Hayward Hotel, 206 W. Sixth St.	(MIchigan 5151)
Mayfair Hotel, 1256 W. Seventh St.	(FItzroy 4161)
Mayflower Hotel, 535 S. Grand Ave.	(MIchigan 1331)
San Carlos Hotel, 507 W. Fifth St.	(MUtual 2291)
Savoy Hotel, 601 W. Sixth St.	(MAdison 1411)
Stillwell Hotel, 838 S. Grand Ave.	(TRinity 1151)
Town House, 639 S. Commonwealth Ave.	(EXposition 1234)
William Penn Hotel, 2208 W. Eighth St.	(EXposition 3181)

A.M.A. Session

American Medical Association will hold its annual session this year in San Francisco. Dates: Monday, July 1 - Friday, July 5, 1946.

[†] For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICES

Announcements of California Procurement and Assignment for Physicians

California Medical Association

San Francisco, February 25, 1946.

C.M.A. Component County Societies, Addressed.

Dear Doctors:

Under date of February 14, 1946, Procurement and Assignment Service for California Physicians issued a directive discontinuing from classification all physicians.

* * *

A copy of the directive of February 14 (I), addressed to all County committees is enclosed herewith for your information.

Also find enclosed copy of a Press Release dated February 19 (II), in re: P. and A. for California Physicians.

Very truly yours,
Philip K. Gilman, M.D., *President,*
George H. Kress, M.D., *Secretary.*

* * *

(I)

(copy)

Federal Security Agency
Procurement and Assignment Service
For Physicians
Roome 1422, 450 Sutter Street
San Francisco 8, California

February 14, 1946.

To: County Committee of Procurement and Assignment Service

From: Harold A. Fletcher M.D., California State Chairman for Physicians' Procurement and Assignment Service.

Subject: Discontinuance Classification of Physicians.

On advice from the Central Board of Procurement and Assignment Service, there will be no further classification of physicians by the State Chairmen of Procurement and Assignment Service. My interpretation of this is that previous classifications of physicians as to essentiality or nonessentiality are void.

As this office is receiving continual inquiries for places to locate, I would appreciate it if county committees would keep me informed as to any community needs so that physicians may be referred to such locations.

The Procurement and Assignment Service program will probably be discontinued in the very near future but I would appreciate the county committees still remaining active until final notice is given.

* * *

(II)

Press Release—*Re: California Procurement and Assignment for Physicians*

(copy)

February 19, 1946.

This is a release by the California State Chairman of Procurement and Assignment Service for Physicians, Doctor Harold A. Fletcher, for all San Francisco newspapers, the Associated Press and the United Press.

* * *

A directive discontinuing the practice of classifying physicians as Essential or Non-essential has been received from the Central Board of Procurement and Assignment Service in Washington by the California State Chairman of Procurement and Assignment Service for Physicians. These instructions have been forwarded to all county committees of Procurement and Assignment Service of California. All previous classifications given to physicians have, therefore, been declared null and void.

The Procurement and Assignment Service was essentially a Selective Service for physicians. The medical profession itself was given responsibility for its success.

The medical, dental and nursing professions were the only groups which were honored with this responsibility during the war. The physicians of California have done an outstanding job not only in meeting the needs of the military forces but also on the home front. They have backed the Procurement and Assignment Service program almost 100 per cent, with the results that they have sent their utmost quotas of physicians to the war and, at the same time, have maintained a reasonably safe margin of medical care reasonably distributed here in California. The records show that no other state has done a better job.

California has fully made the quotas asked for by the military forces and we have never allowed our civilian supply of physicians to go below the level of safety set up on a state basis. The records show that, at the peak of enlistments in 1944, California had one physician to each 1.224 civilian population. The margin of safety is set one physician to 1,500 population. Some states allowed their ratio to sink as low as one to 2.200 on a state level. Other states, comparable to California in population, did not meet their quotas for the military forces and were over supplied with physicians on the basis set up for the emergency. Local shortages in California have occurred in various towns and communities due to rapid unforeseen expansion or often due to the deaths and disabilities of overworked physicians. These shortages were corrected as rapidly as possible and this could only have been done through the utmost coöperation of the medical profession.

The work of the Procurement and Assignment Service will soon be completed. The only remaining problems are the continuing relocation of veteran physicians and the reconversion of the teaching hospitals and medical schools from the accelerated wartime program to normal peacetime service.

I wish to publicly thank the medical profession of California for its loyalty, confidence and coöperation in a job well done.

COUNTY SOCIETIES[†]

CHANGES IN MEMBERSHIP

New Members (5)

Los Angeles (1)

Langan, Arthur J., *Los Angeles*

San Francisco County (1)

Bergeron, W. Lorel, *San Francisco*

Santa Barbara County (2)

Creek, Dale W., *Santa Barbara*

King, Frederick W., *Santa Barbara*

Sonoma County (1)

King, Louise Smith, *Eldridge*

Transfers (9)

Alexander, Elmo, from *Stanislaus County* to *Lassen-Plumas-Modoc County*

Bockrath, Henry M., from *Sacramento County* to *San Francisco County*

[†] For roster of officers of component county medical societies, see page 4 in front advertising section.

Boudett, D. W., from *San Francisco County* to *San Mateo County*
Clarke, Robert W., from *San Joaquin County* to *San Francisco County*
Hatch, Francis N., from *San Mateo County* to *San Francisco County*
Hazel, J. K., from *San Francisco County* to *San Mateo County*
Tuschka, Otto, from *San Francisco County* to *Fresno County*
Weizer, E. A., from *Stanislaus County* to *Santa Cruz County*
Wynns, Harlin, from *Alameda County* to *San Mateo County*

Retired Members (16)

Allen, Orah Knapp, *San Francisco County*
Barber, Edna M., *Alameda County*
Black, Emil C., *San Diego County*
Condit, John C., *Alameda County*
Fernandez, M. L., *Contra Costa County*
Hamilton, James K., Jr., *Alameda County*
Hart, Aden C., *Sacramento County*
Johnson, Murray L., *Alameda County*
Keser, Marguerite D., *Contra Costa County*
Kilbourne, Edwin D., *Santa Clara County*
Kruse, Frieda L., *San Francisco County*
Snure, Henry, *Los Angeles County*
Stephens, William B., *Alameda County*
Torrey, Harry B., *Alameda County*
Wayte, Edwin W., *Los Angeles County*
Wilmar, Alvin H., *San Luis Obispo County*

Life Members (2)

Fairchild, Fred R., *Yolo County*
A. M. Henderson, *Sacramento County*

Resignations (13)

Cutting, Windsor C., *San Mateo County*
Eliason, P. W., *San Mateo County*
Easton, Daniel E. F., *San Francisco County*
Eaton, Avis C., *San Francisco County*
Fritschen, William, *San Francisco County*
Gray, Horace, *San Francisco County*
Honigbaum, Max, *San Francisco County*
Layman, Mary H., *San Francisco County*
Maximov, Gregory M., *San Francisco County*
Piscitelli, Angela M., *San Francisco County*
Richli, Elmira M., *San Francisco County*
Selzer, Jadwiga, *San Francisco County*
Woelz, Emily, *San Francisco County*

In Memoriam

Bingaman, Elmer Wiley. Died at Salinas, January 14, 1946, age 63. Graduate of the University of California Medical School, Berkeley-San Francisco, 1907. Licensed in California in 1907. Doctor Bingaman was a member of the Monterey County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Bryan, Lloyd. Died at San Francisco, December 21, 1945, age 62. Graduate of the University of California Medical School, Berkeley-San Francisco, 1911. Licensed in California in 1911. Doctor Bryan was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Dameron, John Dysart. Died at Stockton, September 25, 1945, age 77. Graduate of the Missouri Medical College, St. Louis, 1894. Licensed in California in 1895. Doctor Dameron was a Retired Member of the San Joaquin County Medical Society, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✣

Doran, Alexander Vincent. Died at San Francisco, January 28, 1946, age 64. Graduate of the University of California Medical School, Berkeley-San Francisco, 1906. Licensed in California in 1906. Doctor Doran was a member of the Solano County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Downing, Samuel Robert. Died at Berkeley, January 19, 1946, age 63. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1915. Licensed in California in 1915. Doctor Downing was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Eastman, William Russell. Died at La Jolla, December 28, 1945, age 72. Graduate of George Washington University School of Medicine, Washington, D. C., 1901. Licensed in California in 1923. Doctor Eastman was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Gilbert, William Henry. Died at Los Angeles, February 3, 1946, age 78. Graduate of Bellevue Hospital Medical College, New York, 1889. Licensed in California in 1914. Doctor Gilbert was a Retired Member of the Los Angeles County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✣

Gius, Enea Augusto. Died at San Francisco, January 4, 1946, age 53. Graduate of Regia Universita degli Studi di Firenze, Facolta di Medicina Chirurgia, 1921. Licensed in California in 1923. Doctor Gius was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Gregory, Hunter Lee. Died at Stockton, November 10, 1945, age 58. Graduate of the Medical College of Virginia, Richmond, 1915. Licensed in California in 1920. Doctor Gregory was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Lamson, Robert Ward. Died at Tujunga, December 31, 1945, age 56. Graduate of Harvard Medical School, Boston, 1925. Licensed in California in 1925. Doctor Lamson was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Pierson, Philip Hale. Died at San Francisco, January 17, 1946, age 59. Graduate of Harvard Medical School, Boston, 1913. Licensed in California in 1915. Doctor Pierson was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Turner, Eldridge Curts. Died at Sacramento, February 10, 1946, age 62. Graduate of the University of California Medical School, Berkeley-San Francisco, 1905. Licensed in California in 1905. Doctor Turner was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

✣

White, Alfred Stevenson. (Lieutenant Colonel, Army of the United States). Died at San Francisco, February 13, 1946, age 38. Graduate of the University of California Medical School, Berkeley-San Francisco, 1932. Licensed in California in 1932. Doctor White was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

Membership Statistics of Some Larger County and State Medical Associations*

County Society	*No. of Members*
I. *New York:*	
(a) Medical Society of the County of New York	5 802
(b) Medical Society of the County of Kings	3 135
(c) Bronx County Medical Society	1,558
(d) Medical Society of the County of Queens	1 219
(e) Medical Society of the County of Nassau	493
II. Chicago Medical Society (Cook County)	5,614
III Los Angeles County Medical Association (Plus several hundred on leave)	3,400
IV. Wayne County Medical Society (Detroit) (Associate Members—680)	2,146
V. Philadelphia County Medical Society	2 800
VI. St. Louis Medical Society	1,235

* * *

Membership totals in the ten largest Constituent State Medical Associations (according to listing in *J.A.M.A.*, April 29, 1944, page 1261) follow:

1. New York	18,908
2. Pennsylvania	9,951
3. Illinois	8 623
4. California	7,550
5. Ohio	6,752
6. Massachusetts	5,528
7. Texas	4 607
8. Michigan	4,567
9. New Jersey	4 294
10. Indiana	3,397

Note. The above figures are only relative and do not indicate membership since V-J Day of year 1945.

Section on General Practice Organized in the Los Angeles County Medical Association

The first meeting of the General Practice Section was a great success. Almost two hundred signed the register, and quite a number came in late so that the auditorium was crowded to the rear wall. It was very gratifying to see quite a few of our friends from the various specialist sections scattered throughout the auditorium.

The meeting was called to order promptly at 8:00 p.m. and a brief statement was made by the chairman pro-tem regarding the purposes of the meeting and the hopes and anticipations. Dr. E. T. Remmen, secretary of the Association, stated briefly the action of the Council in authorizing the formation of the new Section, and added his very congenial words of encouragement and good wishes.

There seemed to be present right from the start a very friendly feeling throughout the audience. The entire meeting was very democratic in spirit. The chairman gave opportunity for members from the floor to express themselves regarding the formation of the new Section and to put forward any ideas they might have on organization.

After free discussion the following resolution was adopted unanimously:

> "Whereas, The general practice of medicine is a branch of the healing art which should rank in all respects with other specialties, and is one which requires ability and training of the highest order on the part of its practitioners, along a broad and comprehensive, rather than a limited and specialized approach, and
>
> Whereas, A substantial number of members of the Los Angeles County Medical Association are engaged in general practice, and are desirous of extending their scientific and fraternal interests, and
>
> Whereas, The Council of the Los Angeles County Medical Association recently authorized the formation of a Section on General Practice.
>
> *Therefore be it Resolved*, That we, general practitioners, members of the Los Angeles County Medical Association, do hereby constitute ourselves a Section on General Practice of the Los Angeles County Medical Association, and be it further
>
> *Resolved*, That a Chairman, a Vice-Chairman, and a Secretary-Treasurer be elected forthwith, and that a Committee be selected to draft by-laws for consideration at the next meeting."

Officers were elected as follows: Dr. Eric A. Royston, Chairman; Dr. Francis R. McCrea of Long Beach, Vice-Chairman; Dr. H. Vern Soper, Secretary-Treasurer. It was voted unanimously that the Program Committee and the Committee on Constitution and By-Laws be appointed by the Chair.

The new little ship has been launched under ideal circumstances. Our sails are unfurled, and we are full of courage as we look towards the broad horizon.

What of the future?

We have a very strong, vigorous Program Committee planning some most excellent meetings for us. These meetings will be held the last Thursday night of each month in the County Medical Association lounge. Anyone who attends these meetings regularly will soon realize that he is getting a most excellent postgraduate refresher course delivered to him free of expense, and with no travel and hotel problem items to be considered.

Having organized our Section in Los Angeles County, we are now in a position to help some of the other County Associations with their organization. It will not be long before this new General Practice Section idea spreads throughout California, and we hope it will be only a few short months before we have a Section on General Practice in the State Association. It is surprising how many inquiries have come in by mail and by telephone.

Sail on, little ship, sail on and on and on!

Eric A. Royston, M.D., *Chairman.*

Physicians for Rural Communities

U. S. Department of Agriculture Calls Attention Thereto

The agriculture department says the country doctors are fighting a losing battle for the health of rural America.

---

* These membership totals of some of the Larger County Medical Societies in the United States sent to Doctor Kress about January 10, 1946, by Doctor Olin West, A.M.A. Secretary. For editorial comment, see p. 115.

Their ranks, says the department, are not being adequately replenished by young, well-trained graduates from modern medical and dental schools.

As a consequence, adds the agency, rural areas—even with their sunlight and fresh air, freedom from industrial dust and fumes, absence of bustling crowds in which communicable diseases can be readily spread—are losing health advantages they once held over urban areas.

In a report on rural health conditions, the department says that because of the shortage of well-trained professional persons, thousands must depend for their medical services largely on untrained midwives, drug-store clerks or cultists.

The department offers rural communities some suggestions for going after some of the young doctors returning from the armed services and for educating future doctors.

* * *

The scarcity of rural doctors is reflected by a survey showing that before the war in the thousand most rural and isolated counties of the nation there were so few medical men that each had to serve an average of 1,700 persons, while in the larger cities there was a doctor for each 650 persons.

During the war the rural average dropped as low as one doctor for 3,000 to 5,000 persons, because rural doctors almost everywhere exceeded their quotas in entering the armed forces.

Doctors and dentists, the report says, tend to shun rural counties because they feel they can make a better living in cities and have greater access to modern hospitals, technical equipment and professional contacts.

The rural shortage also reflects, the department says, a failure of many states to provide educational opportunities for doctors. It says that almost half of all young doctors now come from medical schools in five major industrial states, while 18 states, mostly rural, turn out no medical graduates from their schools.

Emphasizing the need for better health facilities, the report referred to the millions of American young men who were rejected by the armed services because they didn't measure up to military standards.

"Farm people," the report says, "should be more distressed than others because farm youth showed up considerably higher rejection rates than the average. . . . This is the opposite of the situation in the last war, so the health of rural youth is relatively going downhill."

Now that doctors and dentists are returning from war, the department feels that many rural communities could take steps to obtain practitioners. Such communities, it suggests, could offer a doctor an attractive house in which to live and an office in which to work.

* * *

It suggests further that the community offer to provide a prospective doctor with technical equipment, pay his traveling and moving expenses and guarantee him a minimum income for the first year, such as $4 000 to $5,000. This could be done, it is suggested, by agreeing to make up, from county tax funds, any amount by which the income falls short of the guaranteed sum.

It says a rural community could advertise such offers in medical journals.

The department also suggests that rural residents in states without medical schools urge public officials to provide rural medical fellowships—that is, to arrange for the education of a number of medical students on the understanding that they set up practice in a rural community and remain there for five years or so. First preference for such scholarship would be given to country boys.

Another problem, says the department, is "outdated" license laws which keep out physicians and dentists from other states.

License reciprocity could be extended much more among the states, says the department. Better still, it suggests, would be uniform license laws.

* * *

The department suggests also that the national social security system be broadened to provide health insurance for rural people.

"It would not be very difficult," the department says, "to include farm people in social security even though their contributions could seldom be handled through any kind of automatic deductions from wages or income."

Instead of making regular payments, the department suggests, the farmer could contribute once a year, when he pays his income tax, or he could be covered by a "stamp plan," with contributions paid at the postoffice and with receipts in the form of stamps kept in a small book.—San Diego *Union*, January 20.

Doctor-Veterans Are Admitted In Alameda

Alameda County's Medical Association has elected to membership every physician-veteran who has applied since the end of the war, regardless of his place of residence or place of practice before he entered the service.

A statement to that effect was released yesterday by Rollen Waterson, executive secretary of the Alameda county group, in answer to charges private medical agencies have banned the entry of "immigrant" physicians into medical practice in the Bay Area.

"There is no discrimination against any group or class of physicians who apply to the Alameda County Medical Association," Waterson declared.

"We reject only those inadequately trained or those shown to be unworthy of the public confidence."

First complaints on the local medical picture came from returning physician-veterans who charged that the doctors who remained out of service now were making it virtually impossible for others to practice.

The American Civil Liberties Union has lodged a formal protest in Washington against Dr. Harold A. Fletcher, State chairman of both the official Procurement and Assignment, and the Postwar Planning Commission of the California Medical Association.

The A.C.L.U. alleged unconstitutional discrimination is being applied to doctors desiring to "immigrate" to this area.—San Francisco *Chronicle*, February 13.

Red Cross Blood Donor Service — Los Angeles Chapter and Los Angeles County Medical Association

Following is a Memorandum of Understanding between the Los Angeles County Medical Association and the Los Angeles Chapter, American Red Cross.

The Los Angeles Chapter, American Red Cross, is to procure blood from volunteer donors for use in military and civilian hospitals throughout Los Angeles County, all expenses of procurement, typing, and delivery of blood to be financed by the Los Angeles Chapter, American Red Cross. No charge is to be made by any hospital or physician for the blood itself.

Technical Supervisor

A Technical Supervisor, who will serve in a volunteer and advisory capacity, is to be appointed by the County Medical Association.

Personnel

All technical personnel to be employed by the Red Cross must be approved by the County Medical Association.

Technique

Technical practices for the drawing of blood are to be approved by the County Medical Association.

Serology and Typing

The Red Cross will arrange for satisfactory typing of blood and have Kahn serology run on each donation.

Distribution

Blood will be distributed by the Red Cross to hospitals, clinics, and physicians after their request for blood, and facilities for use, have been approved by the County Medical Association.

Medical Care

In event of injury or accident to a volunteer donor, the County Medical Association will make recommendation and arrange for medical care, expenses to be borne by the Red Cross.

Blood Donor Committee

The President of the Medical Association or other representative thereof will serve on the Volunteer Blood Donor Committee of the Los Angeles Chapter, American Red Cross.

Louis J. Regan, M.D., *President,*
Los Angeles County Medical Association.
W. T. Sesnon, Jr., *Chairman,*
Los Angeles Chapter, American Red Cross.

(The above was approved by the Council of the Los Angeles County Society at its meeting February 4.)

* * *

. . . The Council at its meeting November 5, 1945, acting upon the request of Mr. William T. Sesnon, Jr., Chairman of the Los Angeles Chapter of the American Red Cross, to approve of a free blood donor service for Los Angeles County, appointed a special committee with Doctor Howard Bosworth, Chairman, to meet with Red Cross officials to develop a satisfactory working agreement between the Los Angeles County Medical Association and the Los Angeles County Medical Association and the Los Angeles Chapter of the American Red Cross.

Doctor Regan presented a memorandum of understanding between the two organizations and requested Council action. (This memorandum appears elsewhere in this issue.)

Upon motion duly made and seconded, the above memorandum was ordered approved. However, the special committee was requested by the Council to ask the Red Cross to be guarded in public utterances relative to this donor service, especially in news releases indicating that blood was available to all physicians; it being the belief of the Council that blood should be available only when it was to be administered in institutions with adequate facilities. . . .

Alameda County Medical Association Plans Assistance For Returning Doctors

A program of assistance for doctors returning from the armed services has been organized by the Alameda County Medical Association.

To build a fund for this program, physicians who remained out of service have increased their association dues and made other contributions. A portion of this fund has been utilized to employ a realtor to assist doctors in obtaining offices when reëstablishing their practices.

Veterans are not required to pay dues for assessments of the Association, and all qualified physician-veterans who have applied have been elected to the Association, regardless of residence or place of practice before entering the Army or Navy.

The youth of America is their oldest tradition. It has been going on now for three hundred years.
—Oscar Wilde, *A Woman of No Importance, Act i.*

We Americans are children of the crucible.
—Theodore Roosevelt, *Speech,* 9 Sept., 1917.

COMMITTEE ON HISTORY

Los Angeles County Medical Association's Diamond Jubilee

The Bulletin of the Los Angeles County Medical Association, in its issue of February 21, 1946, gave the following account of its 75th anniversary dinner:

Thursday evening, January 31, the Los Angeles County Medical Association ended its seventy-fifth year with a Diamond Jubilee Banquet at the Biltmore Bowl.

Nearly nine hundred—members and wives and friends and guests of the Association, including the officers and councilors of the California Medical Association—took part in the festivities.

Dr. George H. Kress, secretary-treasurer of the State Association and editor of California and Western Medicine, was master of ceremonies. Dr. Kress was asked to serve in that capacity because of his many years of membership in the Los Angeles County Medical Association. Dr. Kress became a member in 1904 and for nine years served as secretary. His knowledge of the history and growth of the Association is not exceeded by any member.

Dr. Kress, after touching on a few highlights of the Association's history, introduced the official family of the California Medical Association and the officers and trustees and councilors of the Los Angeles County Medical Association.

Brought to the rostrum for a special introduction were:

Lula Talbot Ellis, M.D., who joined the Association in 1889, and served as its secretary for the years 1892 to and including 1895. Dr. Ellis, now retired from the active practice of medicine, has retained her active membership status for fifty-seven years, a record that few associations or members can claim.

Dr. Francis M. Pottenger, Sr., who joined the Association in 1901, and served as its president in 1907.

Dr. Raymond G. Taylor, who joined in 1899 and served as secretary during the years 1905, 1906 and 1907.

Dr. William R. Molony, Sr., who joined in 1903 and served as President in 1932, and who recently has been honored by being elected Vice-President of the American Medical Association.

Doctors Philip K. Gilman of San Francisco, President, and Samuel J. McClendon, President-Elect, of the California Medical Association, and Dr. E. T. Remmen, Secretary-Treasurer of the Los Angeles County Medical Association, made brief addresses.

The Bowl floor show and dancing completed the program.

The Anniversary issue of *The Bulletin*—a history of the Association—made its debut at the banquet. Copies of this issue have been mailed to all members, to medical libraries and to officers of numerous medical societies.

Diamond Anniversary of the Los Angeles County Medical Association—Historical Notes

The 75th Anniversary Dinner to celebrate the founding of the Los Angeles County Medical Association was held in the Bowl of the Hotel Biltmore in Los Angeles on the evening of Thursday, January 31st, some nine hundred being in attendance.

The excerpt from the *Bulletin of the Los Angeles County Medical Association* appearing above outlines briefly the proceedings on this historic occasion.

Here additional reference may be made to the motivating spirit among the seven founders, the late Joseph Pomeroy Widney, who also founded the College of Medicine of the University of Southern California; later becoming President of University of Southern California, and protecting that institution from bankruptcy proceedings, through advancement of his own personal collateral.

Officers of the Los Angeles County Medical Association: (left to right) Louis J. Regan, M.D., President; Philip Stephens, M.D., Chairman, Board of Trustees; E. T. Remmen, M.D., Secretary-Treasurer (standing); C. Max Anderson, M.D., Vice-President.

The Diamond Anniversary celebration of the founding of the Los Angeles County Medical Association may be said to have been a brain-child of its present secretary, Doctor E. T. Remmen; to whom credit must also be given for the 200 page 75th Anniversary Number of the *Bulletin of the Los Angeles County Medical Association*, in which will be found the story of the development of a component county unit that is today the third largest county medical society in the United States; also being exceeded in membership number by only some nine of the constituent state medical associations of the American Medical Association. (Statistics on page 136.)

When Secretary Remmen was called upon for remarks at the anniversary dinner, he limited himself to a recital of the graduating address given by Founder Widney to the first graduating class of the College of Medicine of the University of Southern California.

The character of Dr. Widney is excellently portrayed in this address to his first graduating class and appears below.

Also for historical purposes, comments made in CALIFORNIA AND WESTERN MEDICINE for August, 1938, to call attention to the passing of Dr. Joseph Pomeroy Widney are given.

Quotations follow:

FOUNDER WIDNEY'S ADDRESS TO THE FIRST GRADUATING CLASS OF COLLEGE OF MEDICINE, U.S.C. (YEAR 1888)

My Students:

Other men go out from the college classroom to enter upon the stir and bustle of the vigorous life of the world. They go as well men among the well. You go out to the byways of life; to a daily companionship with the crippled, the diseased, the suffering. As you go, some things I would that you should ever bear in mind:

Learn to be patient. Poor broken humanity, in its weakness and its pain, will tax your patience often and again. But remember that it is poor and broken, and that you are to come to it in its impatience and suffering, like Him of old, as a healer. Be very patient and very gentle; remember the infinite patience, and the infinite gentleness of the "seventy times seven."

Be sympathetic. Harshness has no place in the sick room. Let your daily visit be to the sufferer as a daily benediction. Be of pure, clean lives. You are to enter into the homes and the lives of men as can no other. Not even the minister or the priest can so reach the inner lives of humanity. You are to bear its secrets, to know its frailties, often indeed to be its conscience. How shall you be a true healer of men, a healer of souls as well as bodies, if your own lives are full of uncleanness and sin?

Be strong! Strong to carry the burden of humanity in the hours of its extremity; strong to resist its pleadings in the hour when, with soul laid bare, it would persuade you to use your skill to hide sin. For two souls are at *stake—the soul of the one who so pitifully pleads, and your own soul.*

And so, when the last sick call shall have been answered, and the last prescription written, and the tired fingers for the last time lay down the pen, shall you wrap the drapery of your couch about you as one who lies down to pleasant dreams; and so shall you pass down to the valley of the shadow, fearing no evils.

And so shall you not dread to meet the face of the Master, who was also a healer of men.

* * *

ON THE PASSING OF JOSEPH P. WIDNEY, FOUNDER OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION

Excerpts from C. and W. M., August, 1938

To have lived to the ripe old age of 97, with a mind keen and alert up to its last hours, despite such physical handicaps as a frail body and practical blindness, is an experience that has not often come to human beings. Yet such was the life of Dr. Joseph Pomeroy Widney,* whose death took place at Los Angeles on July 4, 1938.

Doctor Widney, it will be recalled, was the motivating spirit in the founders group which organized the Los Angeles County Medical Association on January 31, 1871, some sixty-seven years ago, and he—who in recent years was the oldest living graduate of the University of California (having received his M. D. degree from Toland Medical College in 1866)—also founded the College of Medicine of the University of Southern California in the year 1885. Later, in the financial panic of the nineties, he resigned as dean of the University of Southern California Medical Department in order to take over the responsibility of saving the University of Southern California at a time when its properties were about to be levied on by the courts; guaranteeing with his personal resources as he assumed the presidency the payment of the claims pending against the institution.

Born in Ohio in 1841, so far back that he recalled a childhood amid the wigwams of Indians, a soldier in the War Between the States and an assistant surgeon in Indian campaigns in Arizona, while successful as a physician in private practice in Los Angeles, he became the founder of a county medical society that is today one of the largest in the United States. He was also founder and dean of a medical school, and president and protector and saviour of the University of Southern California in its early days of life and death struggle. As a civic worker he had a broad and far-seeing vision of railroad.

Master of Ceremonies and four of senior members of Los Angeles County Medical Association, selected for special honor. (Left to right) George H. Kress, M.D., Master of Ceremonies; Lula Talbot Ellis, M.D., Raymond T. Taylor, M.D., F. M. Pottenger, M.D., William R. Molony, M.D.

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* Biographical sketches of the late Dr. Joseph Pomeroy Widney appeared in CALIFORNIA AND WESTERN MEDICINE in the following issues: Vol. 44, No. 4, April, 1936, page 292; Vol. 44, No. 5, May, 1936, page 396; Vol. 46, No. 6, June, 1937, page 398; Vol. 49, No. 2, Aug., 1938, pp. 106 and 161.

harbor and other developments, on a massive scale, for the southern section of California. Also minister of the gospel, and founder of a settlement house, and devotee of the gospel work, author of volumes of historical and other essays,[†] including a large two-volume "Race Life of the Aryan People," he proved himself a kindly philosopher, with a mind richly stored with knowledge of the past, and ever alert and inquiring as to the significance of current changes and events. Dr. Joseph Pomeroy Widney's life was indeed such as is granted to but few men to enjoy.

And so, once more, a great man has been gathered to his fathers.

* * *

The following two essays, "Why Is Death?" and "Heaven," both written by Doctor Widney a few days before his death, at age 97, are printed *In Memoriam* to a beloved physician, whose name the California Medical Association may well place on its honor roll, and for all time to come.[†]

WHY IS DEATH?

Across the pathway of life, and apparently bringing it to an end, is Death, and from the earliest antiquity men have been asking the question, "Why death at all?" "Does it serve any useful purpose in the Drama of Life?" The answer is Yes, without death the drama of life would be a failure. The purpose of that drama is—The Making of a Man: not simply for time, but for eternity. That making is what has been called Evolution. Through all the years of his life man has been growing. It is the law of evolution, that is, of growth. The planet grows. It is first a gaseous nebula. It then becames a habitable world. The man's body through which he works is a necessary attendant upon that life. A man may will that a brick shall place itself at a certain point in a wall which he is building—it does not obey. But he may will that hand to take that brick and put it into its proper place. It is a matter acting upon matter through the use of matter. It is so in all phenomena of life. The subtle and intangible will of the spirit has acted upon matter. But in this circuitous way, man realizes that he is hampered and restricted in his work.

Man is restricted in his knowledge of the world about him. He had thought that the seven prismatic colors were all. By using the chemical paper, he now knows there is an infra-red and an ultra-violet which he does not see. It is so in every department of human inquiry. It is so in the pitch, in the low and the high notes in music, and it is so in all the broad field of strange, intangible rays of power and light that come to us from the universe about us.

Shall man be stopped in his intellectual evolution by the limited range of the possibilities of further investigations in the universe about him, because of the material limitations of the body through which, in this life, he must work? There is no escape from these limitations unless he is released from the body which defines them. This is why Death! Death is simply *release* that men may go on.

This is what every religion tries to explain. Man set free from the shackles that impede his progress that he may go on. It is not a calamity. It is a blessing in disguise. It is like the blessing of toil placed upon primitive man that he might work and progress.

The idle man in Paradise had failed. The man who went out from Eden to toil with the briars and brambles of a fertile earth that he might have food succeeded.

But the time comes when a man, even with all his achievements, reaches the limit. He can go no farther in a lifetime. Is his progress to cease? Death in this life has answered the question. Death is not a calamity! Man may still go on; Death may be the sum total of his experiences. It is the greatest blessing to man that God has made. Die—and go on!

Is this death to be all or does Eternity hold other deaths yet to come?

We deem that this life is not all, but is only one stage in the evolution of man upon earth. Eternal life upon this planet is withheld from man. The story is thus told in Genesis III, Verses 22, 23, 24.

(22) "And the Lord God said, Behold, the man is become as one of us, to know good and evil: and now, lest he put forth his hand and take also of the tree of life, and eat, and live forever:

(23) "Therefore the Lord God sent him forth from the garden of Eden, to till the ground from whence he was taken.

(24) "So he drove out the man: and he placed at the East of the Garden of Eden Cherubim, and a flaming sword which turned every way, to guard the way of the tree of life."

Eternal life upon earth—do we realize what it would mean? The body grows old—it has worn out its material envelope. Age, and a life properly lived, brings with it maturity. After maturity there follows decay.

* * *

HEAVEN[*]

Heaven—What is it?—When?—Where?

What conclusions must we draw from the many beliefs of the ancient and modern writers? Only one conclusion will be possible, that we are mistaken utterly in the meaning of the word Heaven. Everywhere in the Universe we find the law of eternal growth and eternal deterioration. It seems to be the same in every department of the Universe—material, intellectual, and spiritual. The pleasures of heaven lie in the thought:

I, too, am a sharer in the development of the worlds about me, a sharer with God, therefore forever sharing in the mind of the Supreme Maker of the Law. Was this not the deeper meaning of the word spoken by the Supreme Ruler—when discussing the future of man upon earth, *"He will become as one of us—knowing good and evil"*? The thought is, if in this lower sphere man should eat of the tree of life and live and gain eternal life, would it be death to his soul?

Life as we know it upon this plane is to be lived by successive births and consequent deaths: the soul progressing and developing in accordance with the fixed and unchanging law spoken in the beginning.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Governor Warren Signs Bill for U.C.L.A. Medical School

Sacramento Feb. 19.—Governor Earl Warren today signed the Davis bill appropriating $7,000 000 to establish a medical school at the Los Angeles campus of the University of California.

"I don't know of any appropriation bill before me that would give me more satisfaction to sign than this one," the Governor said.

Standing about him in the executive office were members of the Legislature who had a hand in pushing the bill through, as well as a group of doctors, including Drs. Rupert Rainey, Harry Friedgood, Myron Prinzmetal, Wilbur Bailey and Elmer Belt, all of Los Angeles.

Warren Statement

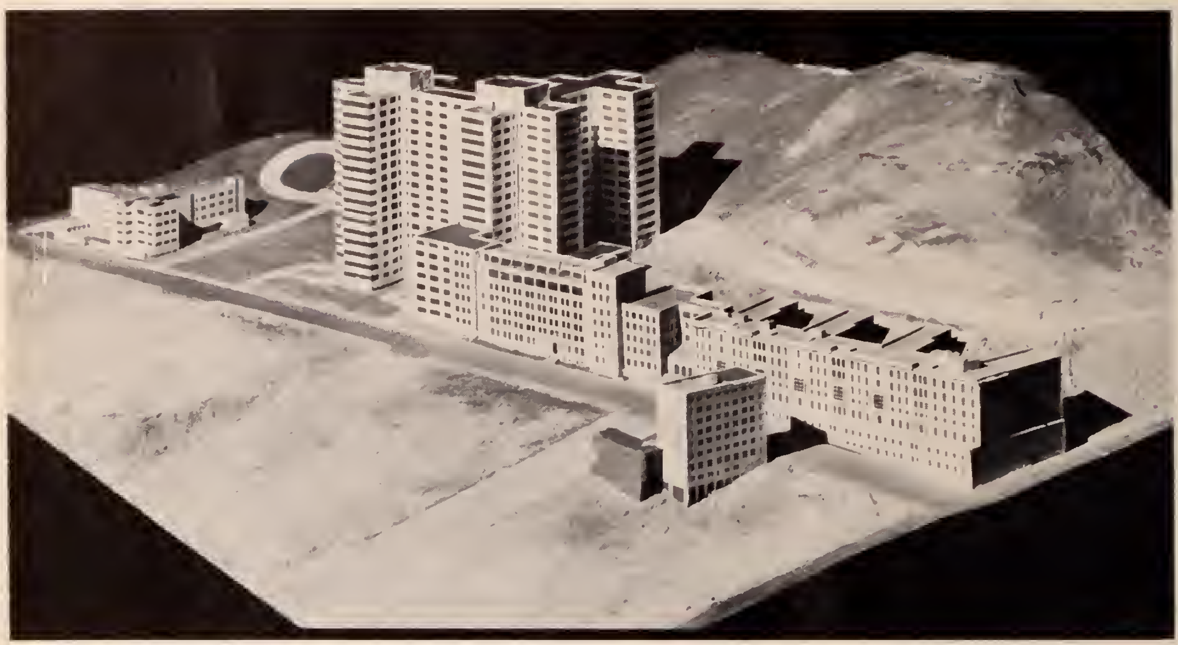
"I believe we can do as much good for the people of the State in this manner as any way of spending the money," Warren said. "I hope we can get this center under way quickly and that it will become one of the great medical centers of the country."

He thanked Dr. Belt for what he termed "the education" the doctor had given him last summer on the urgent need for a medical training center at the university in Los Angeles.

Others attending the ceremonies were Charles Lyon, Speaker of the Assembly; James Corely, controller of the university; Assemblyman Phil Davis, in whose district U.C.L.A. is located; State Sen. Jack Tenney, and Assemblyman Ralph Dills, chairman of the Los Angeles County delegation.—Los Angeles *Times*, February 20.

[†] Doctor Widney was the author of the following Volumes: 'Race Life of the Aryan Peoples," "The Lure of the Land," "Three Americans," "A Greater Los Angeles," "A New Europe," "A New Orient," "Studies of Other Worlds."

[*] This essay was dictated by Dr. Joseph P. Widney on June 29, 1938, his death occurring five days later, on July 4, 1938.



Photograph, through courtesy of Mr. Timothy L. Pflueger, architect of new buildings for University of California Medical School in Medical Center at San Francisco. The large group in the center is the new Teaching Hospital and the Sciences Building (to be erected), and immediately in front of that is a low structure which is part of the Sciences Building. Just to the right of the Sciences Building is the existing Clinic Building, then the present Hospital, and immediately in front of the present Hospital is the existing Nurses Home. In the distance, to the left, is the Langley Porter Clinic.

U. C. Hospital and Medical School in San Francisco Plans "Finest Plant" With Fund

The four million dollars appropriated by the Legislature for the University of California Hospital at Third and Parnassus avenues is only part of the money needed to complete the long-range plans for the medical school and hospital. (For editorial comment, see page 118.)

Two new large buildings are planned, a medical science school to replace the old red brick building dating back to the 19th century and a new and modern teaching patient hospital.

The present hospital building would be used exclusively for private patients.

The university, like all medical schools, must provide facilities for private practice to attract the caliber of physicians and surgeons that are necessary for a top-rank school.

Architect Timothy Pflueger is preparing plans for buildings which will each be "18 or 20 stories high." He said construction will begin sometime in 1946 and the project will be finished in a few years. "It should give the U. C. Medical School one of the finest plants in the United States—and that means the world," according to Superintendent S. F. Durie.

The superintendent said the chief problem was to sandwich in the new buildings on the hilltop campus here, without interfering with the continued use of the old ones.—San Francisco *News*, February 7.

Comment on Special Session of California Legislature

After mixing good and evil, the special session of the Legislature has adjourned. It appropriated more than a quarter of a billion dollars. . . .

It did several things which meet with general approval. It broadened the base of aid to veterans and refurbished the veterans' code. It appropriated $154,000,000 for a State institutions building program, which was correct under the principle that State interests are first, as was its Federal fund-matching appropriation for flood control. It made possible a medical school and center at the University of California at Los Angeles, filling a need that was not debatable. It made other desirable appropriations in the general interest of the State, but spoiled its good record here by letting die the bill to aid poor school districts. This was a necessary measure and its demise is deplorable. . . .—Excerpt from editorial, Los Angeles *Times*, February 21.

Educator Warns on Keeping Young Physicians in Military Services

In Chicago, on February 11, a prominent medical educator asserted high American medical standards might be "compromised" by keeping young physicians in the Army and Navy too long. Dr. Perrin H. Long, director of the department of preventive medicine at Johns Hopkins University, expressed this view in a talk prepared for the forty-second annual congress on medical education and licensure.

"The selection of the bulk of young medical men in this country for service in the armed forces interrupts this program and transfers these individuals to the relatively limited sterile fields of military medicine, at a time in their careers when their seeds of productivity in medical research normally begin to sprout," said Long.

"Present standards of American medicine will be compromised unless these young men are returned to the laboratories and clinics of this country within a reasonable period."

* * *

Dr. Wilburt C. Davidson, dean of the Duke University medical school, asserted a tour of European medical schools and clinics convinced him medical education abroad "is not as good as most physicians formerly thought.

"It has been profoundly affected by the war, both by the mental restrictions of the German occupation as well as by the actual physical destruction in Great Britain, France, Italy and Germany."

* * *

"The United States today is the medical center of the world," asserted Dr. George F. Lull, associate general manager of the American Medical Association in Chicago, and formerly deputy surgeon general, United States Medical Corps.

"Better medicine is being taught and practiced in this country than in any other place."

* * *

Dr. Ray Lyman Wilbur of Stanford University, chairman of the American Medical Association's council on medical education and hospitals, joint sponsor of the congress with the Federation of State Medical Boards, praised American medical colleges.

Their graduates, he said, during the last 25 years have done "the best practical job in medical care and public health that has ever been done in the history of the world."

CALIFORNIA PHYSICIANS' SERVICE†

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* * *

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W. M. Bowman, Executive Director
A. E. Larsen, M.D., Medical Director
W. H. Gardenier, M.D., Assistant Medical Director

On February 2nd, the Board of Trustees of California Physicians' Service held a joint meeting with the Fee Schedule Committee, for the purpose of reviewing certain items where there was a difference of opinion as to the proper fee.

After a thorough review of these items, and considerable discussion, agreement was reached on all items with the exception of the section on Radiology. Inasmuch as it was impossible for a representative of this section to appear at any of the hearings, it was suggested that this phase of the schedule be referred to the Pacific Coast Roentgen Society for immediate action.

On February 3rd, the Board of Trustees held a regular meeting.

Legal Counsel reported that in the case of C.P.S. vs. the Insurance Commissioner, the case had been argued orally in the Supreme Court, and a decision may be expected within three or four months.

The board unanimously approved holding the Annual Meeting of Administrative Members in conjunction with the meeting of the House of Delegates of the C.M.A.

On Acquisition for December, Mr. Bowman reported a total enrollment of 14,141 persons—4,401 in the North and 9,740 in the South. Total beneficiary membership is approximately 182,300.

Dr. Larsen reported enrollment of 155 new professional members in December. Total professional membership is now 5,897. During the month, 165 member physicians reported returning from military service, and were sent current information on C.P.S. and its operations.

Dr. Cooley reported that he and Mr. Bowman attended the meeting of the Sacramento County Society for Medical Improvement on January 15th. Most of the complaints presented in the report of that Society some months back have been corrected. Since that meeting, some 60 doctors have affirmed or re-affirmed their support of C.P.S., and there are now more than 70 doctors in Sacramento county willing to render service to C.P.S. beneficiary members.

A letter from Hospital Service of Southern California, requesting the discontinuance of the San Diego District Office, was presented. After considerable discussion, the board voted that this office should be maintained by C.P.S.

In connection with financial reports distributed to the trustees, Mr. Bowman reported that the Commercial Program deficit has been reduced from $259,000 to $196,000 and the reduction should continue at the rate of from $25,000 to $35,000 a month. The rate increase is 97 per cent complete. Administrative expense for the past five months has been 17.9 per cent. Mr. Ralph R. Nelson, actuary, is reviewing recent statistical material, and will furnish a report to the board.

Dr. Larsen reported that the liquidation of the Housing Program, completed January 1st, proceeded very smoothly, with excellent reaction in the communities affected.

On the Rural Program, after discussion with Regional Officers of the Farm Security Administration, it has been agreed that when contracts with the individual Farmers' Health Associations expire, the members will be transferred into the regular surgical and hospital coverage under the Commercial Program. The Grange Program is starting shortly, and the first meeting with a Grange Group will be held in February. This will mean that coverage will be available to any farm group, but that C.P.S. will be operating under its Commercial Program only, at one unit value, and with just two contracts—the medical and the surgical. It is felt that this will meet with the whole-hearted approval of the profession and the rural population of the State.

In answer to a question from Dr. Doughty concerning the enrollment of doctors who had been in military service as beneficiary members, together with their families and employees, Mr. Bowman stated that there would be a re-opening in March.

Dr. Cooley and Mr. Bowman reported their recent visit to Montana, for a special meeting of their House of Delegates at which time Montana Physicians' Service was organized. C.P.S. is furnishing advice and assistance, but neither C.P.S. nor the C.M.A. will incur any expense. New Mexico and Nevada have also asked for assistance in setting up prepaid care plans, and Arizona has expressed an interest.

Developments in the field of a national prepaid care plan were reported to the trustees. Mr. Bowman was authorized to represent C.P.S. at the meeting of the Council on Medical Service Plans and Public Relations of A.M.A., in Chicago on February 12th, and Dr. Gilman was authorized to represent C.P.S. at the meeting of State Presidents prior to that.

On the contract with the Veterans' Administration, it was reported that while numerous conferences have been held with the Veterans' Office in San Francisco and Los Angeles, these offices have not yet received their instructions from Washington. Until these instructions have been received, C.P.S. will authorize no care. Meanwhile, forms and procedures are being worked out to ensure smooth and simple operation of the program. As soon as the local offices have received their instructions and the details are worked out, C.P.S. will advise all practicing physicians as to how the program will function.

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† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161.
Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

C.P.S. was asked to provide hospitalization for veterans on a State-wide basis. A tentative contract has been submitted. The board approved the offer of hospitalization to veterans until the hospitals or the Blue Cross Plans are willing and able to do so. The business of C.P.S. is medical care, and C.P.S. would handle hospitalization out of necessity only, since the Veterans' Bureau will deal with just one organization on a State-wide basis.

Mr. Hassard reported that the C.M.A. Advisory Planning Committee has prepared a report to the C.M.A. Study Committee, answering certain questions raised by the latter committee. This report will remain unpublicized until after its presentation to the Study Committee.

Dr. Moore reported briefly on a recent meeting of the Study Committee.

The board approved the continuation of a $2.00 unit for March and April.

CHESTER L. COOLEY, M.D., *Secretary.*

California Physicians' Service

153 Kearny Street, San Francisco 8
EXbrook 0161
713 South Grand View, Los Angeles 5
DRexel 5261

* * *

V.A.—C.P.S. Fee Schedule

For convenience in future reference C.P.S. has given permission to print in CALIFORNIA AND WESTERN MEDICINE the V.A.-C.P.S. fee schedule, which follows:

(COPY)

VISITS AND EXAMINATIONS

(001-049)

		Maximum Charge
001	Office visits	
	First call (routine history and physical examination)	$ 5.00
	Follow-up calls	2.50
002	Hospital visits	3.75
	Hospital visits—10 P.M. to 6 A.M.	7.50
003	Home visits	
	First visit	5.00
	Follow-up visits	3.75
	Home visits—10 P.M. to 6 A.M.	7.50
004	Visits to additional members of same household—At home	2.50
005	Consultation (in which case is *returned* to referring physician for treatment)	
	In the office	10.00
	At home	15.00
006	Consultation by referral (in which second physician *continues* with case)	
	First visit	7.50
	Follow-up calls	2.50
007	Complete history and physical examination (on authorization of Medical Director and only in cases with obscure diagnostic problems)	15.00
008	Complete neurological examination	15.00
009	Detention with patient in critical condition	
	Per hour—day time, at home or hospital	10.00
	Per hour—after 10 P.M.	15.00
010	Mileage—per mile one way, from 3 miles beyond city limits	.50
—— to 049		

SPECIAL DIAGNOSTIC PROCEDURES

(050-099)

050	Abdominal paracentesis	$ 5.00
051	Allergy tests—scarification or intradermal (Costs of materials to be paid by patient)	
	20 tests	5.00
	For each additional 10	2.50
	Maximum	37.50
052	Audiogram	5.00
053	Barany test	10.00
054	Basal metabolism	5.00
055	Biophotometer tests—for Vitamin A deficiency	5.00
	Repeats	2.50
056	Blood Transfusion (not including cost of blood)	15.00
057	Electrocardiogram	7.50
058	Spinal puncture	5.00
059	Thoracentesis (diagnostic)	5.00
060	Visual fields (neurological)	5.00
—— to 099		

GENERAL SURGERY

(100-199)

Infections and Traumata (100-129)

100	*Burns	
	First degree	$ 5.00
	Second degree	
	less than ⅓ of an extremity	7.50
	more than ⅓ of an extremity	15.00
	(An extremity shall be considered to be hand and arm to shoulder; foot and leg to hip; head and neck to body; body)	
	Subsequent dressings requiring more than 15 minutes, $2.50 for each additional 15 minutes.	
	Third degree burns, requiring anesthesia depending on area involved—minimum	25.00
	Larger fees for extreme destruction of tissue.	
101	*Carbuncle—excision	25.00
102	*Grafts, pinch	15.00
103	*Superficial abscesses and boils—incision	5.00
104	*Other abscesses—incision and drainage	10.00
105	*Tendon of hand—drainage	25.00
106	*Traumatic wounds	
	Repair of recent small wounds, to 2½ inches	5.00
	Repair of recent small wounds, involving subcutaneous tissue and requiring buried suture or ligature	7.50
	Repair of recent large wounds (over 2½ inches)	10.00
	Repair of recent large wounds involving subcutaneous tissue and requiring buried suture or ligature	15.00
	Foreign body removal	
	Single superficial	3.75
	Multiple superficial	5.00
	Under skin, requiring incision to remove	6.25
	Under deep structures, requiring open operation to remove	15.00
107	*Ulcer—excision	10.00
—— to 129		

Cysts (130-139)

130	Aspiration	$ 5.00
131	Branchial cyst—removal	125.00
132	Complicated cyst	25.00
133	Dermoid cyst	75.00
134	Pilonidal cyst or sinus—complete excision	75.00
135	*Sebacious cyst—removal	
	Large	7.50
	Small	5.00
136	Thyroglossal cyst—removal	200.00
—— to 139		

Tumors (140-149)

140	*Complicated external—removal	$ 25.00
141	*Epithelioma (Explain extent and procedure—fee adjusted accordingly) Minimum	5.00
142	*Epulis—removal	15.00
143	*External papiloma (removal)—Keratosis	5.00
144	Paratoid—removal	75.00
145	Vocal cord tumor—removal	75.00 T
—— to 149		

Biopsy (150-154)

150	Bone biopsy	$ 10.00 T
151	Superficial biopsy	5.00 T
152	Viascopes	25.00 T
—— to 154		

Glands (155-159)

155	*Superficial glands—removal	$ 10.00
—— to 159		

Thyroid (160-164)

160	Lobectomy	$125.00 T
161	Thyroid gland, simple ligation	75.00 T
162	Thyroidectomy	175.00 T
—— to 164		

Breast (165-169)

165	*Breast abscess, drainage	$ 10.00
166	*Breast tumor, biopsy or enucleation of small tumor	25.00
167	Radical removal	200.00 T
	(Skin grafts over 1 inch diameter, add $27.50)	
168	Simple removal	100.00 T
——	to 169	

Miscellaneous (170-179)

170	Ligation, saphenous vein	$ 37.50 T
171	Toe nail, ingrown—removal	12.50 T
172	Varicose veins, injection (medication furnished by patient)	5.00
——	to 179	

Casts (Medium Not Included) (180-189)

When not otherwise charged for, as in dislocations and fractures.

180	Body jacket	$ 25.00
181	Extremities—hand or foot	5.00
182	Extremities—leg or forearm	10.00
183	Full upper or lower extremity	15.00
184	Removal of plaster cast	5.00
185	Removal of cast containing pins and wires used for fixation	10.00
186	Spica—single	20.00
187	Spica—double	25.00
——	to 199	

Anesthesia and Assistants (190-199)

190	Anesthesia, major	$ 20.00
191	Anesthesia, minor	10.00
192	Anesthesia, whenever gas furnished by anesthetist	20.00
	Per Hour	10.00
193	Spinal anesthesia	10.00
194	Assist at major operation	30.00
195	Assist at minor operation	10.00
——	to 199	

SPECIAL SURGERY

(200-649)

Thoracic Surgery (200-219)

200	Bronchoscopy, diagnostic, including biopsy	$ 50.00 T
201	Bronchoscopy, operative	100.00 T
202	Empyema, rib resection	50.00
203	Phrenic nerve, crushing	25.00
204	Pleura, paracentesis	5.00
205	Pneumothorax, artificial—first	15.00
	Refills—each	7.50
206	Thoracoplasty—first stage	200.00
	Each additional stage	50.00
207	Thoroscopy—cutting pleural adhesions	62.50 T
208	Thoroscopy—diagnostic	37.50 T
——	to 219	

Abdominal Surgery (220-289)

220	Abdomen—paracentesis	$ 5.00
221	Abdomen—peritoneoscopy	37.50 T
222	Appendectomy	125.00 T
223	Appendiceal abscess, drainage	75.00 T
224	Biliary drainage—duodenal tube	5.00
225	Cholecystectomy	200.00 T
226	Cholecystotomy	150.00 T
227	Colon, resection	200.00
228	Colostomy	125.00 T
229	Diverticulum, intestinal	125.00 T
230	Esophagoscopy	50.00 T
231	Esophagus, dilatation	25.00 T
232	Gastrectomy	200.00
233	Gastro-enterostomy	200.00 T
234	Gastrostomy	50.00 T
235	Gastrotomy	150.00 T
236	Hernia, femoral, single	100.00 T
237	Hernia, femoral, bilateral	125.00 T
238	Hernia, reduction by taxis, single	10.00
239	Herniotomy, inguinal, single	100.00 T
240	Herniotomy, inguinal, bilateral	125.00 T
241	Herniotomy, umbilical	100.00 T
242	Intestines, anastomosis	150.00 T
243	Intestines, resection	200.00
244	Laparotomy—exploratory, for diagnosis or biopsy	125.00 T
245	Splenectomy	200.00 T
246	Ulcer, duodenal, excision	200.00 T
247	Ulcer, peptic, perforated, closure	150.00 T
——	to 289	

Proctology (290-319)

290	*Abscess, ischio-rectal, drainage	$ 25.00
291	*Fissurectomy	25.00
292	Fistulectomy—simple	50.00
293	Fistulectomy—complicated horseshoe fistula	75.00
294	Hemorrhoidectomy—external	25.00
295	Hemorrhoidectomy—internal	100.00 T
296	Hemorrhoids, injections—each	5.00
297	Incision — of small abscess, thrombotic hemorrhoid, papilla, skin tags	10.00
298	Pectenotomy	50.00
299	Perirectal abscess, drainage	5.00
300	Polypectomy (excision or fulguration)	50.00
301	Proctoscopy	5.00
302	Prolapsed rectum, repair	150.00
303	Rectum—radical resection or amputation for malignancy	200.00
304	Sigmoidoscopy—surgical	10.00
305	Sphincter, dilatation	5.00
——	to 319	

Urology (320-359)

320	Bladder tumor, fulguration	$ 50.00
321	Bladder irrigation	5.00
322	Catheterization of urethra or passing sound	5.00
323	Circumcision—adult	20.00 T
324	Circumcision—infants, 6 mo. to 1 yr.	12.50 T
325	Circumcision—new born	5.00 T
326	Cystoscopy, diagnosis (bladder only)	12.50
327	Cystoscopy, with catheterization of ureters	25.00
328	Cystoscopy, operative, for neoplasm	100.00
329	Cystotomy or cystostomy	50.00
330	Epididymectomy	50.00
331	Hydrocele, radical operation	50.00 T
332	Nephrectomy	200.00 T
333	Nephropexy	200.00 T
334	Nephrotomy	200.00 T
335	Orchidectomy	50.00 T
336	Orchidectomy—radical, for malignancy (explain procedure used)	150.00
337	*Phimosis—dorsal slit	10.00
338	Prostatectomy—any method	200.00
339	Prostatic abscess	62.50
340	Prostatic resection—transuretheral, median bar	100.00 T
341	Renal lavage	12.50
342	Tuncia vaginalis, paracentesis	5.00
343	Ureteral stone through cystoscope	50.00 T
344	Ureterotomy	125.00 T
345	Urethroscopy	10.00
346	Varicocele operation	50.00 T
347	Vasectomy Bilateral	37.50 T
——	to 359	

Obstetrics and Gynecology (360-419)

360	Abortion or miscarriage (if hospitalized and curretted)	$ 50.00
361	Atresia of vagina, correction of	50.00
362	*Bartholin's Gland—excision	25.00
363	*Bartholin's Gland—incision	10.00
364	Caesarian Section, abdominal	150.00 T
	(Add 20 per cent of OBS fee if prenatal care was given)	
365	Caesarian Section, vaginal	150.00 T
366	Cauterization of cervix	5.00
367	Cervical polyp—in hospital, wtih currettage	50.00 T
368	Cervix—amputation	75.00
369	Cervix—dilatation of	25.00 T
370	Cervix—repair of tear	37.50
371	Colporrhaphy	100.00
372	Conization of cervix	37.50 T
373	Cul-de-sac, drainage	50.00
374	Currettage—diagnostic or therapeutic	50.00 T
375	Cystocele repair	100.00 T
376	Fistula, recto-vaginal	125.00
377	Fistula, vesico-vaginal	125.00
378	Hysterectomy, radical, for cancer	200.00
379	Hysterectomy, simple, non-malignant	150.00 T
380	Hysterectomy, simple, non-malignant	150.00 T
381	Labial tumors and cysts, removal	37.50
382	Myomectomy, with laparotomy	150.00 T
383	Oophorectomy (one or two)	150.00 T
384	Perineorrhaphy—chronic cystocele and rectocele and trachelorrhaphy	150.00 T
385	Perineorrhaphy—relaxed perineum	100.00
386	Pregnancy—prenatal care, delivery (spontaneous or forceps), supervision of child in hospital, postpartum care, including final examination	100.00 T
	Pregnancy—delivery and postnatal care	75.00
	Pregnancy—prenatal care only	25.00
387	Pregnancy—ectopic, ruptured	150.00
388	Rectocele repair	100.00 T
389	Salpingectomy (one or two)	150.00 T
390	Salpingo-oophorectomy	150.00 T
391	Trachelorrhaphy	50.00 T
392	Urethral caruncle, removal	20.00 T

393	Uterine flexions, etc., correction	150.00 T
394	Uterine polypi, removal	37.50 T
395	Vaginal plastic—including cystocele and rectocele	150.00 T

—— to 419

Ophthalmology (420-459)

420	*Canthotomy	$ 7.50
421	Cataract, removal	150.00 T
422	*Chalazion	5.00
423	*Conjunctiva, suture	25.00
424	*Conjunctival flap for corneal ulcer, etc.	15.00
425	*Cornea, paracentesis	12.50
426	*Corneal ulcer, cautery	7.50
427	*Corneal ulcer, deliminating keratotomy	37.50
428	Entropion or ectropion, plastic operation	62.50
429	Entropion or ectropion, Ziegler's puncture	37.50
430	Enucleation of eye	100.00 T
431	Enucleation and implantation	87.50
432	Evisceration	62.50
433	Foreign body, interior eye, removal	125.00
434	*Foreign body, removal from cornea	5.00
435	Glaucoma, filtrating operation	125.00
436	Iridectomy	62.50 T
437	*Lachrymal duct stenosis, probing	7.50
438	Lachrymal sac, removal	62.50
439	Pterygium	37.50 T
440	Ptosis	125.00
441	Refraction with mydriatic	12.50 T
442	Retinal detachment (multiple fusions)	175.00
443	Strabismus, one stage	75.00
444	Strabismus, two or more stages	100.00
445	Symblepharon, release	37.50
446	Tarsorrhaphy, orbicularis paralysis	37.50
447	*Trichiasis, electrolysis	17.50
448	Tumor, exenteration of orbit	125.00
449	Visual fields (neurological)	5.00

—— to 459

Otology (460-469)

460	Audiometer test	$ 5.00
461	Mastoidectomy, acute	125.00
462	Mastoidectomy, bilateral	200.00
463	Mastoidectomy, radical	150.00
464	*Paracentesis tympani (myringotomy)	10.00

—— to 469

Nose and Throat (470-489)

Where it is necessary to operate on any combination of procedures the fee shall be for the major procedure plus 25 per cent of the fee for each other procedure.

470	Antrum, Caldwell-Luc	$150.00
471	Antrum, Caldwell-Luc—bilateral	175.00
472	Antrum, puncture	5.00
473	Ethmo-sphenoidectomy	50.00
474	Eustachian Tubes—catheterization and inflation	5.00
475	Laryngectomy	200.00
476	Larynx, intubation	25.00 T
477	*Nasal polyp, removal	7.50
478	Naso-antral window	37.50
479	Naso-antral window—bilateral	50.00
480	*Peritonsillar abscess	10.00
481	Submucous resection	75.00 T
482	Tonsillectomy and adenoidectomy	50.00 T
483	Tracheotomy	50.00
484	*Turbinectomy	10.00
485	Uvulectomy	5.00

—— to 489

Neuro-Surgery (490-509)

490	Chordotomy, bilateral	$125.00
491	Chordotomy, unilateral	125.00
492	Craniotomy for tumor, abscess, depressed fracture	200.00
493	Decompression, subtemporal	125.00
494	*Encephalogram — introduction of material (x-ray extra)	25.00
495	Laminectomy, cord tumor or nucleus pulposus	200.00 T
496	Laminectomy, intervertebral disc	150.00
497	Lumbar puncture	5.00
498	Nerve anastomosis (Individual consideration)	125.00 down
499	Section, anterior scalenus (scalenus syndrome)	75.00
500	Section, 5th nerve (tri-geminal neuralgia)	125.00
501	Section, 8th nerve (Meniere's syndrome)	125.00
502	Skull defect, plastic operation	125.00
503	Splanchnicectomy	200.00
504	Trephine, subdural hematoma	75.00
505	*Ventriculogram — introduction of material (x-ray extra)	50.00

—— to 509

Bone—Joint—Tendon Surgery

Fractures (510-569)

Uncomplicated—Closed Reductions

Fee includes two weeks after-care. Thereafter home, office, hospital calls allowed except where "T" is indicated.

510	Acetabulum	$ 62.50 T
511	Carpal	25.00
512	Clavicle	50.00 T
513	Colles' Fracture	62.50
514	Femur	100.00
515	Forearm—one bone	37.50 T
516	Forearm—both bones	62.50
517	Humerus	50.00 T
518	Ilium	62.50 T
519	Leg—one bone	50.00 T
520	Leg—both bones	75.00
521	Mandible	37.50 T
522	Maxilla	20.00 T
523	Metacarpals	25.00
524	Metatarsals	25.00
525	Nasal Bones	25.00
526	Olecrenon	37.50 T
527	Os Calcis	25.00 T
528	Patella	50.00 T
529	Pelvic	62.50 T
530	*Phalanx of finger	5.00
531	Phalanx of toe	10.00
532	*Phalanx—each additional	5.00
533	Pott's Fracture	75.00
534	*Ribs	10.00
535	*Ribs—two or more	20.00
536	Sacrum	62.50 T
537	Scapula	50.00 T
538	*Skull	25.00
539	Sternum	20.00
540	Tarsal	25.00

If Fracture is comminuted or compound or multiple or involves a joint, enough to interfere with reduction and control, add 50 per cent to fee for simple fracture.

Open reduction with internal fixation, for bone plating or bone splinting or inlay, two times fee for simple fracture.

Skeletal traction, including use of tongs, wires, pins, add 50 per cent to fee for closed reduction.

For bone graft of ununited fracture, three times the fee for treating the original fracture.

For bone drilling for delayed union or ununited fracture, same fee as for treating original fracture.

Open operation for removing splinters of bone from open wound, simple sequestrum, plate, screws, or internal splint material: charge fee for simple fracture.

Reduction of vicious union by use of Thomas wrench, add 50 per cent for simple fracture.

—— to 569

Dislocations (570-579)

570	*Dislocations—easy reductions without anesthetic or assistance	$ 10.00
571	*Dislocations—major reductions under anesthesia	25.00

—— to 579

Joint Surgery (580-594)

580	Acromio-clavicular separation—repair of	$150.00
581	Arthrodesis—shoulder, elbow, sacro-iliac, hip or knee	200.00
582	Arthrodesis—wrist, ankle, foot	100.00
583	Arthroplasty—shoulder, elbow, hip or knee	200.00
584	Arthrotomy—large (shoulder, knee)	75.00
585	Arthrotomy—small (ankle, wrist)	50.00
586	*Aspiration—small joints (ankle, wrist)	5.00
587	*Aspiration—large joints (shoulder, knee)	12.50
588	Cartilage, semi-lunar—removal of detached	100.00 T
589	Disarticulation at hip or shoulder joint	150.00
590	Ligaments, knee—repair of crucial	150.00
591	Ligaments, knee—repair of lateral	100.00
592	*Manipulation of joints or back—under anesthesia	25.00
593	*Manipulation of joints or back—simple	5.00
594	Patella—repair of recurrent dislocation	100.00

Other Orthopedic Procedures (595-649)

595	Albee or fixation operation	$200.00
596	*Amputations—finger or toe	15.00
597	*Amputations—finger or toe—each additional	5.00
598	Amputations—foot, ankle or leg	75.00
599	Amputations—hand, wrist, forearm, arm	75.00
600	Amputations—knee or thigh	100.00
601	Amputations—hip	150.00
602	Astragalectomy	100.00
603	Bunion operation, plastic—one foot	62.50
604	Bunion operation, plastic—both feet	100.00
605	Boehler Method (os calcis fracture with cast)	125.00
606	Bursa—excision of, large	50.00
607	Bursa—excision of, small	30.00
608	Bursa—injection of novocaine	12.50
609	Bursa—repair of wounds or removal of foreign bodies—50 per cent of fee for excision	
610	Fasciotomy—Ober's	75.00
611	Ganglion—removal of	37.50
612	Laminectomy	200.00 T
613	*Lavage—of shoulder joint for calcified bursa	25.00
614	*Osteomyelitis, acute — small incision for drainage	25.00
615	*Osteomyelitis, acute — large incision for drainage	50.00
616	*Osteomyelitis—sequestrectomy—small	50.00
617	*Osteomyelitis—sequestrectomy—large	75.00
618	Removal of metatarsal heads	25.00
619	Removal of carpal bones	37.50
620	Removal of spinous process	37.50
621	Removal of spurs and exostoses	37.50
622	Smith-Peterson operation (sacro-iliac)	200.00
623	*Tendon surgery—lengthening	62.50
624	*Tendon surgery—sutures, each tendon (not to exceed $200.00 T)	37.50
625	*Tendon surgery—tenotomy (subcutaneous) (two or more, add 50 per cent)	30.00
626	*Tendon surgery—transplants	75.00
	Transplants—each additional (not to exceed $150.00)	37.50
627	Traction skeletal, when not part of fracture fee otherwise charged	12.50
——	to 649	

PATHOLOGY

(650-799)

Tissue (690-659)

650	Surgical pathological diagnosis	$ 10.00
651	Frozen section	25.00
——	to 659	

Sputum (660-669)

660	Smear for tubercle bacilli	$ 2.50
661	Concentration method for tubercle bacilli	5.00
662	Pneumococcus typing	5.00
——	to 669	

Stomach Contents (670-679)

670	Fractional tests (meal, alcohol and/or histamine)	$ 10.00
671	Gastric Analysis	5.00
——	to 679	

Feces (680-689)

680	Microscopic examination (parasites and ova)	$ 5.00
681	Occult Blood	.50
——	to 689	

Spinal Fluid (690-699)

690	Diagnostic spinal fluid (includes cell count, globulin flocculation)	$ 10.00
691	Diagnostic spinal fluid—plus collodial gold (additional)	2.50
692	Diagnostic spinal fluid—plus glucose (additional)	2.50
693	Extra tests (see Blood)	
——	to 699	

Bacteriological Examinations (700-709)

700	Direct smears (gonorrhea, trichomonas, etc.)	$ 2.50
701	Culture—simple	2.50
702	Animal inoculation	5.00
703	Guinea pig inoculations for tuberculosis—one pig	7.50
704	Guinea pig inoculations for tuberculosis—two pigs	10.00
——	to 709	

Urines (710-729)

710	Routine chemical and microscopical	$ 1.50
711	Quantitative—sugar or albumen (only)	.50
712	Phenolsulphonthalein (charge patient for dye)	
	Bladder urine—2 samples	2.50
713	Phenolsulphonthalein—cystoscopic, both ureters	3.75
——	to 729	

Blood (730-789)

730	Agglutination tests—3 antigens, Widal, etc.	$ 5.00
	Each additional antigen	1.25
731	Blood Culture (of recognized diagnostic value)	5.00
732	Blood Typing and Matching	2.50
	($2.50 for each of first two tests. Subsequent tests after first two done during consecutive period of observation of illness)	1.25
	(Patient and more than three donors in search for compatible blood) Maximum	10.00
733	Calcium	5.00
734	Chloride	5.00
735	Cholesterol	5.00
736	Coagulation and bleeding time	1.50
737	Complete blood count—hemoglobin, red blood count, white blood count, differential	5.00
738	Complete blood count—requiring call to home	10.00
739	CO_2 determination	7.50
740	Creatinine	5.00
741	Fragility of corpuscles	5.00
742	Glucose	5.00
743	Glucose tolerance (1 hour, 2 dose test, or 1 and 2 hour methods) 5 samples	10.00
744	Hemoglobin—chemical	1.25
745	Hemoglobin—Talquist	.50
746	Heterophile antibody	5.00
747	Icterus index	2.50
748	Liver funotion tests	7.50
749	N. P. N.	5.00
750	Phosphatase	5.00
751	Phosphorus	5.00
752	Platelet count	2.50
753	Red count and hemoglobin	2.50
754	Reticulocyte or platelet count (to be added on to other charges for blood examination)	1.25
755	Sedimentation rate (graph)	5.00
756	Sedimentation time	2.50
757	Smears for parasites (malaria, etc.)	1.50
758	Sugar—quantitative in blood	5.00
759	Sulpha drugs—blood level	5.00
760	Urea	5.00
761	Urea clearance	7.50
762	Uric Acid	5.00
763	Vandenberg (quantitative or qualitative)	2.50
764	Wassermann, Kahn, Kline or Hinton (selection of one—checks not allowed extra)	3.00
765	White count and differential	2.50
766	White count and differential and hemoglobin	3.75
——	to 789	

Moiscellaneous (790-799)

790	A. Z. test	$ 5.00
791	Friedman	7.50
792	Basal Metabolic Rate	5.00
793	Dark field, for Treponema Pallida	5.00
794	Electrocardiogram, with interpretation and report	7.50
——	to 799	

RADIOLOGY

(800-889)

800	Abdomen—for pregnancy	$ 10.00
801	Abdomen—plain examination	10.00
802	Additional procedures (such as stereoscopic oblique projections of lumbar articulations) in conjunction with routine examination	33% additional
803	Barium enema	15.00
804	Barium enema and gastro-intestinal series	35.00
805	Bladder or cystogram	10.00
806	Broncography (including opaque oil and injection)	20.00
807	Cervical spine	15.00
808	Check-up examinations of fractures (within 24 hours)	At one-half original charge
809	Chest plate	10.00
810	Cholecystography (including dye)	15.00

811	Cholecystography — and gastro-intestinal series	35.00
812	Consultation on examinations made at outside offices	10.00
813	Encephalography	25.00
814	Entire spine, complete studies	35.00
815	Eye, for foreign body	10.00
816	Eye—foreign body localization	20.00
817	Finger, fingers, toe or toes	5.00
818	Fluoroscopic examination	5.00
819	Fluoroscopic examination — in conjunction with procedures such as myelography, requiring unusual time	10.00
820	Foot, heel or ankle	7.50
821	Full denture	10.00
822	Gall bladder (plain examination)	10.00
823	Gastro-intestinal series, complete, including barium enema and cholecystography	45.00
824	Gastro-intestinal series, with barium enema OR cholecystography	35.00
825	Gastro-intestinal series, without barium enema or cholecystography	25.00
826	Hand, wrist or elbow	7.50
827	Kidneys or plain KUB	10.00
828	Knee, hip or femur	10.00
829	Lumbar spine	12.50
830	Lumbosacral spine	15.00
831	Lungs and heart, including fluoroscopy	15.00
832	Mastoids	12.50
833	Nasal bones	10.00
834	Oesophagus	15.00
835	Partial denture	5.00
836	Pelvimetry	20.00
837	Portable examinations at patient's home (additional fee)	15.00
838	Pyelogram (intravenous, including dye and administration)	25.00
839	Pyelogram (retrograde)	15.00
840	Ribs or sternum	12.50
841	Salpingography	20.00
842	Shoulder, scapula or clavicle	10.00
843	Sinuses	12.50
844	Skull—complete examination	20.00
845	Skull—for sella turcica or bones of face	12.50
846	Thoracic	12.50
847	Tooth	1.25

—— to 849

Radiological Therapy (850-888)

(Per Treatment Visit)

850	Adenitis	$ 5.00
851	Cancer—superficial (depending on size, location and technical difficulties)	10.00-100.00
852	Hemorrhagic conditions—prolonged coagulation time, etc.	5.00
853	Infections and Inflammations—carbuncles, furuncles, paronychia, etc.	5.00
854	Keratosis	5.00
855	Skin conditions—Acne dermatitis, erysipelas, wart, etc.	5.00

Minor or intermediate roentgen treatments may need repetition, especially minor ones, as much as five times. If more than six such minor treatments are considered necessary in any one case, special authorization shall be obtained.

856	Cancer of breast, prostate, testis, bladder, uterus (complete course, 3 to 6 weeks' treatment, treatments being given daily or close together)	200.00 T
857	Pre and postoperative (complete course) in conjunction with surgery	150.00 T
858	Preoperative irradiation (short intensive course)	50.00 T
859	Hyperthyroidism (complete course)	100.00 T
860	Menorrhagia, fibromyoma uteri	100.00 T
861	Single treatment	10.00

—— to 888

Includes preliminary clinical examination, consultation, current visits and use of equipment or cost of providing radium.

By full course of roentgen or radium irradiation is meant approximately three to six weeks of roentgen treatment, the treatments being given daily or close together, however large a number of fields is used. The fee shall include preliminary clinical examinations, consultation and all current visits.

Unclassified radium entitles where authorization for global fee has not been obtained and where part of medical fee has or has not already been paid—(or above)—1.5 cents per milligram hour, plus insertion charge $12.50 to $25.00 (depending on difficulties of the medico-surgical procedure).

889 Services not otherwise classified

General Instructions

1. Fee includes surgical procedure and two weeks after care except where "T" is indicated. Where "T" is indicated, the fee is total.
2. Starred items (*) indicate fee for surgical procedure itself, after care additional.
3. Assistants bill C.P.S. separately.
4. Anesthetists bill C.P.S. separately.
5. Medical follow-up during surgery and postoperative care by a second physician is *not* allowed, except in cases where complications develop and attending surgeon requests consultation. In such instances authorization from Medical Director must be obtained. Emergency operations at night, 10 p.m. to 6 a.m., add 50 per cent to minimum fee.
6. Unusual cases and those not specifically listed are entitled to the same fee as a listed procedure of closest similarity.

Home Town Medical Care for Veterans

The sensible and economical home medical service guaranteed to California veterans through agreement between the Veterans' Administration and California Physicians' Service adds to the debt of gratitude the American people owe Veterans' Administrator General Omar N. Bradley.

He is an administrative genius who knows what he wants for the veterans—and gets it. He forced long-needed service reforms in veterans' hospitals. He put an end to political log-rolling in the building locating of hospitals. And the problem he has licked with the coöperation of California doctors was a knotty one. This State already has 1,300,000 ex-service men and women. Of World War II veterans, nearly 70 per cent claim service-connected disabilities. The great majority are not ill or incapacitated enough to require separation from their homes and jobs in veterans' hospitals, but do need the best in medical service as out-patients, and are entitled to it without delay, red tape or personal cost.

The problem has been solved simply and permanently. After February 1, any veteran determined eligible by the Administration for out-patient care at Government expense may go to any C.P.S. doctor for treatment. The doctor will be paid on the basis of a fee schedule set up in the contract between C.P.S. and the Administration.

There are C P.S. medical men in every community. It is due to the progressiveness of the California Medical Association, which pioneered the field of voluntary prepaid medical care by organizing and financing California Physicians' Service, that the type and standard of health service sought by General Bradley was in readiness in the State.

Undoubtedly the California program will be a pattern for national emulation. Every veteran whose physical well-being was impaired in the service of this country is certainly entitled to the finest of medical care. And California is indeed fortunate that this service can be provided on a home-town basis, without government regimentation of either the veteran or the medical profession. —Lower Lake *Observer*, January 17.

Veterans Assured Medical Care in California

California veterans, under the terms of a contract just completed in Washington between General Omar N. Bradley, veterans' administrator, and California Physicians' Service, today were assured of prompt, home-town medical care at government expense for service-connected disabilities which do not require hospitalization, with the right to choose their own doctors from the 6,000 professional members of C.P.S.

The far-reaching veterans medical care program, designed to eliminate delays and red tape by enabling service men who need treatment, but not hospitalization, to be cared for in their own communities, will be available to California service men of World War I and the Spanish-American War, as well as those of World War II

California has approximately 1,310,000 veterans of the three wars, it was announced, and nearly 70 per cent of currently discharged veterans are claiming service-connected disabilities. The new plan becomes operative on February 1, 1946, and will be put in operation within a few weeks thereafter, as fast as arrangements can be made.

William Bowman, executive director of California Physicians' Service, in announcing the program, quoted General Bradley and Major General Paul R. Hawley, acting surgeon general of the veterans' administration, as declaring:

"We are very pleased to make this contract with California Physicians' Service because it assures California veterans of high quality medical care in their own home communities."

The Veterans' Administration, Mr. Bowman announced, will screen veteran applicants to determine those eligible for out-patient care at government expense and will certify them to C.P.S. The veteran can then go to any C.P S. doctor for treatment; the doctor will send his bill to C.P.S. which, in turn, will bill the government. The doctors will be paid on the basis of a fee schedule set up in the contract between the Veterans' Administration and C.P.S.

California Physicians' Service, a voluntary health insurance system founded eight years ago by the California Medical Association, embraces in its professional membership the great majority of California doctors, both general practitioners and specialists, and its membership extends into every community in the State.—Richmond *Record-Herald*, January 10.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

"Jobless Pay For the Sick" Bill Passed By California Legislature

Final legislative approval was given by the Senate on February 14 to the establishment of a State system of unemployment disability payments.

An abortive last-hour attempt was made to torpedo the Shelley bill, setting up the machinery for the disability payments to an estimated 2,600,000 workers under unemployment compensation insurance.

The move involved charges that industry and business representatives were attempting to renege on amendments written into the measure, and countercharges that labor representatives had sneaked in Assembly changes in the original bill. But the final roll call showed the Senate voting, 26 to 10, to concur in the amendments.

The bill now goes to Governor Warren for his signature. Warren urged the Legislature to enact the measure. Senator Shelley, principal proponent of the act, has been working on the program for more than six years. During the past four years a Senate interim committee has also worked on the measure. Shelley was chairman of the committee and the members of the group were co-authors of the bill given final approval.

The purposes of the Shelley bill are to compensate in part for the wage loss sustained by workers unemployed because of sickness and injury and to reduce suffering caused by unemployment resulting therefrom.

Under the measure a worker, if eligible, will be entitled to both unemployment compensation disability benefits and unemployment compensation benefits in the same year.

Disability Insurance

It is quite appropriate that the State Senate should scrutinize closely provisions of Senator Jack Shelley's disability insurance bill (a Warren Administration measure) but justice forbids that the measure should be killed by amendments, rather than by a straight-away vote upon its merits.

Action upon it has been held up in the Senate by introduction of amendments. One of these, introduced by Senator Ward of Santa Barbara, would prohibit payment during any one year of both sickness and unemployment benefits to the same person. This would almost completely defeat the purpose of the legislation.

Obviously a worker may be unemployed at one time and ill at another and thereby suffer serious personal loss in each case. Or unemployment and illness might occur simultaneouslly which would be even a more disastrous experience. Unemployment insurance is intended to tide a worker over the period of no income. Disability insurance is to help him pay the cost of getting well. They are entirely distinct in purpose and should not be confused in legislation.

True, the bill proposes to pay disability benefits out of unemployment insurance fund. But that is perfectly logical inasmuch as workers have contributed almost 300 million dollars to the fund by their payroll deductions. It is to their interest and that of the employers to receive proper medical care in order to keep them fit for productive work and their earning power unimpaired. Proper attention during illness, which the bill guarantees, would be an aid to that end.

California and three other states require worker contributions to the unemployment insurance fund. One of the others, Rhode Island, sets aside the entire worker contribution for disability insurance.

Our state's unemployment insurance fund now totals 733 million dollars, of which, as we pointed out, the workers have contributed approximately 300 million dollars. Department of employment statisticians estimate that even under extreme depression conditions, with widespread joblessness, the employers' share would be more than adequate to pay unemployment benefits. They also figure disability payments would, under extreme conditions, not exceed 35 million dollars a year, whereas worker payments into the fund average about 47 million dollars.

This money comes out of the workers' pay envelopes. The employer can pass his share on to his customers in increased prices. It is only a matter of simple justice to grant that the workers are entitled to extra benefits from their share of the fund. This is particularly true in California and the three states that tax the workers for the fund. In all the other states the workers, who pay nothing, receive the same benefits now allowed workers in this State. Surely California workers are due more protection because they share the burden.—San Francisco *News*, January 30.

Michigan Doctors Concerned Over Trend Toward Socialized Medicine

The continued drift of the nation toward state socialism, although to a lesser degree than in the case of England under the Attlee labor government, is illustrated by President Truman's message to Congress (Nov. 19) advocating national compulsory health insurance.

It is not the presumptuous intention of this column to proclaim judgment on the merits of national health insurance. We do feel, however, it is proper and timely to present the viewpoint of the average Michigan physician and surgeon, as represented by his state professional organization, and to outline briefly the general issue involved.

Medical care is a subject that reaches into the intimate lives of every man, woman and child in every community of Michigan.

Health insurance typifies the growing controversy over voluntary vs. compulsory action as a solution of our many complex problems.

* * *

Prior to World War II, compulsory health insurance had been adopted by twenty-nine countries with a combined population of more than 500,000,000.

Five additional nations, as a substitute for compulsory health insurance, granted government subsidies to volunteer organizations (sponsored by doctors) which insured their members in an acceptable manner. They are: New Zealand, Belgium, Sweden, Denmark and Spain.

The American movement began about 1915 following the adoption in England of the British Insurance Act of 1911. However, the idea was not received favorably at the time. The American Medical Association went on record against it in 1920; among the critics were insurance companies, many employers' organizations, druggists and patent-medicine manufacturers, the American Federation of Labor through President Gompers and the executive council, and several religious groups. It was denounced as being un-American, socialistic, a wrong method of attack, and a death blow to the personal relationship between doctor and patient—just to mention a few objections.

* * *

After considerable discussion, the Michigan medical profession chose to do something about it.

The Michigan State Medical Society, 4,800 members strong, evidenced its progressive leadership by recognizing the basic need for prepaid health insurance.

Instead of compulsory insurance under government control, the Michigan remedy was this: Two volunteer non-profit corporations, the Michigan Medical Service and the Michigan Hospital Service, each chartered by the state legislature in 1939 whereby any citizen is eligible to subscribe to low-cost insurance covering both medical and hospital expenses.

Today the Hospital Service has more than 1,000,000 members; the Medical Service, close to 900,000. No other state health insurance program has begun to approach this outstanding success. Michigan not only leads the entire country; it leads the world.

* * *

Paradoxically, Michigan's progress reveals and emphasizes a weakness of the American medical profession.

While 868,000 persons are now insured in Michigan against medical expense incurred during ill health, only 200,000 are so protected in Massachusetts and 175,000 in California, second and third ranking states in voluntary health insurance.

To dispel the apathy prevailing elsewhere, the Michigan medical society last April invited presidents of 17 state groups in the Middle-West to a conference in Detroit. Its success led to the calling of a western regional conference in Colorado last June for ten states.

And finally, in an effort to induce national action, the coöperating 27 states—led by Michigan—sponsored a national conference in Chicago held on December 2, 1945.

While Michigan leaders remain discreetly silent, doctors admit privately that Michigan's leadership has not received the blessing and support of the august and distinguished American Medical Association which remains officially aloof, now as in the past, from the field of social insurance.

* * *

The dilemma of Michigan doctors is clear.

No matter how perfect Michigan's insurance program may become, Michigan alone cannot stem the spreading tide of socialized medicine.

Unless all state medical societies coöperate for positive local action, some degree of national health insurance appears now to be inevitable within a decade. Our economic loss due to illness is tremendous. Quoting President Truman: "On the average day there are about 7,000,000 persons so disabled by sickness or injury that they cannot go about their usual tasks."

The number of days lost by illness is forty times greater than the time involved in industrial strikes over a ten-year period.

Forty per cent of counties in the United States lack a hospital; this deficiency is particularly severe in rural areas.

* * *

You can't blame the Michigan doctors for being genuinely concerned.

If voluntary medical insurance can meet the challenge, national insurance and control may be averted. Can the "forest fire" be stopped? Is there time?

It is another test of the free entreprise system; of the voluntary coöperation vs. state collectivism.

History insists that every great war is followed by drastic change. A sharp swing to the left, bringing socialization of our modern economic life, would inundate the institution of private medicine just as it would everything else. The doctor's dilemma affects us all.—By Gene Alleman, Michigan Press Association.

Proposed Federal Bill, H.R. 5296—Re Income Tax Deductions for Free and Charity Services Rendered

(COPY)

Congress of the United States
House of Representatives
Washington, D.C., February 15, 1946.

Dear Sir:

You will agree with me, I am sure, that the rising cost of living has affected the physicians, surgeons and dentists perhaps more adversely than any other key group in American life.

It is my thought that the economic burden upon the members of these professions might be appreciably eased, if appropriate recognition were made of the tremendous volume of non-remunerative work carried on by the physicians, surgeons and dentists of the United States—such recognition to be made, in a very practical way, by the Commissioner of Internal Revenue.

Accordingly, I have introduced a Bill (H. R. 5296) in the House of Representatives specifically allowing physicians, surgeons and dentists to enter as a deduction in their income tax, a credit equal in terms of percentages to the amount of time they devote each year to charity, free clinical work and public research work. A copy of the Bill is attached for your immediate reference.

It is my hope that this Bill will meet with the approval of your membership, and further, that you will take action to help bring the matter to the favorable consideration of the Congress. In this connection, it would appear essential that the Ways and Means Committee of the House be made aware of the widespread public interest in this urgent question. It is, therefore, my hope that you will find it possible to write to the members of that Committee—their names are given on the list attached—urging that hearings be set at the earliest possible moment. Naturally, such action on your part will be most effective if you will write to those members of the Committee representing the area nearest your residence.

In order that I may be kept aware of your activities, and follow through appropriately from the Washington end, may I suggest that you send me copies of your letters?

I shall be most interested in hearing further from you.

Sincerely yours,

(Signed) CLAIRE BOOTHE LUCE,
(Member Congress, 4th District Connecticut)

California members of the Ways and Means Committee of the House:

(Address: c/o House Rep. Office Building, Washington, D. C.)

Cecil R. King, of Los Angeles, California.
Bertrand W. Gearhart, of Fresno, California.

* * *

79th Congress, 2d Session
H. R. 5296
In the House of Representatives
January 30, 1946

Mrs. Luce introduced the following bill; which was referred to the Committee on Ways and Means

A BILL

To amend the Internal Revenue Code, as amended, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 23-q of the Internal Revenue Code is amended by adding the following new paragraph, to read as follows:

"(4) That commencing with the taxable year 1946, physicians, surgeons, and dentists shall be allowed an additional credit as a deduction on their income tax equal in terms of percentages to that portion of their time each year which is devoted to charity, free clinic work, and/or public research work;

"(5) The Commissioner of Internal Revenue shall prescribe by regulation the method of computing such time and the proof which shall be required in substantiation thereof."

Association of American Physicians and Surgeons (AAPS) Writes President Truman — Dr. Parran, Surgeon General, Replies—AAPS Answers the Surgeon General

Complying with a directive from the A.A.P.S. House of Delegates, Dr. Harold T. Low, president of A.A.P.S., strongly objected to President Truman's compulsory insurance plan in a letter addressed to the President on November 28, 1945. The A.A.P.S. president informed Mr. Truman that members of A.A.P.S. would not participate in any such scheme and gave the Association's reasons for such refusal.

Dr. Thomas J. Parran, Surgeon General of the United States, replied for the President on December 26, 1945. The Surgeon General's response suggested an implied threat against the Association because of its stand of non-participation. . . .

The Association answered Dr. Parran's letter on January 10, 1946. . . .

Copies of the three letters follow in date sequence. All physicians are urged to read them carefully—particularly Dr. Parran's reply. They give an indication of what the American medical profession can expect if the profession and the unsuspecting public are ever dosed with compulsory health insurance and resulting socialization of medicine. . . .

* * *

Association of "American Physicians and Surgeons" Response to Dr. Parran's Letter

January 10, 1946.

Doctor Thomas J. Parran,
Surgeon General of the United States
Public Health Service,
Washington 14, D.C.

Dear Doctor Parran:

We have received your letter of December 11, which is in reply to our letter of November 28 addressed to President Truman.

Our American form of government is indeed, as you point out, a representative form of government in which it is intended that the will of the people shall be expressed through the acts of the Congress, and this Association believes in and is loyal to that system of government.

In our letter to the President, we informed him that members of this Association would not service any compulsory health insurance program because it would inevitably lead to deterioration of medical care. In reply you state: "It is therefore an alarming symptom that any responsible group—especially a professional group—should take a position of non-coöperation, even of boycott, of a proposed law if such law be enacted." Further, you say: "The President has asked me to say that an overwhelming majority of the people would condemn your Association's policy of non-coöperation; and that he does not believe that any appreciable number of physicians and surgeons would join in your program—certainly not if they understood the significance of what they would be doing."

If these quotations from your letter correctly reflect the view of the President, may we ask if he has had a change of heart, for, in a public statement on November 19, the President is quoted as saying physicians would remain free to accept or reject patients and decide whether to participate in the system (compulsory health insurance) full time, part time, or *not at all.*

May we ask what is implied in the warning by the President that physicians would not join in our program "if they understood the significance of what they would be doing." Are we to infer that there is, after all, behind this bill a program or purpose of forcing physicians into the plan? If there is, this is the time for the physicians, and their patients as well, to know what it is and how it is proposed to carry it out. We construe your language to be a veiled threat against those who choose to remain out and the forerunner of coercive measures not yet revealed. We have the right to immediate full disclosure on this point.

We presume the President means what he said on November 19. Therefore, why is it "an alarming symptom"?—why is it "non-coöperation"?—and why should we be "condemned"? The members of this Association merely decline to participate in schemes of compulsory health insurance, which the President has publicly declared is their right.

You speak of "boycott—on the people of the United States." The Association of American Physicians and Surgeons proposes no present or future boycott against the people—our patients. Were compulsory health insurance legislation to be enacted we would care for our patients just as we always have, and we would let them know that our services are rendered as free men and not as serfs of the State. As to our rights as physicians to remain out of the scheme, we do not construe the President's declaration of November 19th to this effect as a concession or grant to us, but merely as the recognition by him of an inherent right, guaranteed by the Constitution of the United States, which we possess. Members of the Association will never "strike" agaisnt our present rightful employer, the people—our patients, but we are serving unequivocal notice of a permanent and unalterable "strike" against an improper potential employer—the State.

Our aim is to preserve the most efficient progressive and finest system of medical practice in the world against the tragic threat that is carried in your proposal.

In your letter you dismiss the possibility of deterioration of medical care (under a scheme of compulsory health insurance) with a bland statement that you do not believe the danger "is supported by experience."

We are confident that you, as a physician, will concur with the quite prevalent belief that up to now the "free" medical care dispensed by the Veterans' Administration is one of the most glaring examples of the failure of federalized or socialized medicine. Also, as a physician, you should know that compulsory health insurance, providing for the government to fix and pay physicians' fees, is socialization of medicine. A comparison of health records of this country with those countries which have schemes of government control of medicine, strongly supports our statement, "Any compulsory health insurance program would inevitably impair the quality of medical care received by the people."

Voluntary health plans are expanding, as rapidly as is commensurate with healthful growth, in 22 of the states, with many more states in the process of reorganizing plans suited to their individual needs. The people have to be educated in many cases to the value and need of insurance against the expenses of serious illness, actuarial standards to determine the cost of various types of coverage have to be developed, high standards must be maintained, and certain abuses have to be eliminated. All of this represents orderly evolutionary change in a desirable direction, which we feel is vastly to be preferred to the revolutionary disorderly change which you propose. Rome was not built in a day. Look at the record of American Medicine and consider whether you wish to jeopardize this record by advocating the sort of socialistic and Utopian change which some less fortunate nations than ours (i.e., Germany, England, Australia) have adopted only to have serious and extreme disintegration of the quality of care received by the people of these nations follow in the wake of such change.

Under the circumstances, every physician is under the most urgent moral obligation to oppose what you are asking the Congress to do, and by every means at his command; and his obligation would be in no way lessened if such proposals were enacted into law. To a physician, *as a physician,* the welfare of his patient is the highest law and paramount to everything. When this is no longer possible, he stops being a physician. Remember the President said that physicians may exercise their judgments as to whether they should work under the proposed law, and we intend to consider the welfare of the patient as of the highest importance in making up our minds on the subject.

The President has said that the people of the United States will have a health insurance program just as they have fire insurance. The utter lack of analogy is too clear for argument. People take fire insurance if they want it, and not because somebody forces it upon them. Moreover, they pay a premium which is comparable to and based upon the risk involved—not upon their income and earnings. Under the plan outlined in Senator Wagner's pending bills, there is no relation whatever between the amount assessed against an insurance individual and the risk of covering him. This violates every principle of insurance of whatever kind or nature. The essence of the fallacy in this scheme is that men do not pay in proportion to their probable benefits or risk of coverage, but an arbitrary sum (taxes) designed to pay for something that somebody else gets.

When you can propose any plan for the improved distribution of medical care that will, at the same time, retain or enhance the quality of the care, you will find every physician in the country solidly supporting you.

However, no compromise is possible with the basic fundamental principle of individual initiative and reward for competency, skill and industry, so that we cannot do other than to remain unalterably opposed to any form of compulsion in this sphere, because any such scheme is incompatible with our fundamental beliefs as Americans and our fundamental rights and duties toward our fellow man, as citizens generally and as physicians specifically.

Very truly yours,

Association of American
Physicians and Surgeons,
Harold T. Low, M.D.,
President.

COMMITTEE ON POSTGRADUATE ACTIVITIES

Obstetrical and Gynecological Assembly of Southern California

Applied psychiatry has become a matter of primary concern in the treatment of gynecological and obstetrical patients.

That thesis was expounded on February 19 to 100 physicians and surgeons meeting at the Elks Club in the Obstetrical and Gynecological Postgraduate Assembly of Southern California.

The speaker was Dr. Paul A. Gliebe, who pioneered adult sex education at the University of California's School of Medicine at San Francisco.

While most of his discourse, the second of ten lectures he will give before the week-long conference, was highly technical, Dr. Dr. Gliebe gave an interview immediately after the morning session to describe his theories in lay terms.

Problems Provoked

"We have learned in psychosomatic medicine," he said, "that emotional problems provoke tensions in human beings, leading to well-recognized physical complaints and disorders.

"How to meet these problems is becoming more and more a topic of sober discussion in medical-surgical circles."

Whole clinics, Dr. Gliebe said, are now devoted to the study and cure of "emotional ailments." Among these is U.C.'s Langley-Porter Clinic in San Francisco.

"Conversely," he went on, "we are making every effort to discover the physiological factors that operate in producing psychological disorders. How can we 'cure' these emotional complaints—which frequently develop to such a degree that they are actually diagnosed as asthma, epilepsy, ulcers, heart disease, or even hay fever?

"We must educate adolescents before they acquire harmful psychoses.

Parental Factor Stressed

"And," Dr. Gliebe said flatly, "we must educate parents themselves. Mothers and fathers can implant ideas and fixations in their children that will, in later years, break forth as genuine emotional ailments."

Dr. Gliebe characterized the current increase in divorces as a "wave of domestic unrest." But he said that the war did not bring it about. Rather, he explained, the war is being used as an "excuse by the 75 per cent of the married couples who would have separated anyhow." He feels that this situation will "level off."

Doctors attending the conference, which probably will become an annual "postgraduate course" to disseminate America's latest obstetrical and gynecological knowledge to Southwesterners, viewed an elaborate display of postwar medical and surgical equipment, much of which is manufactured locally.—Los Angeles *Times*, February 20.

Los Angeles Health Group Conference—Disease Prevention Week

Educators, health workers and physicians in Los Angeles, attended a Biltmore civic luncheon in one of the main observances of Disease Prevention Week. Dr. Walter H. Brown, dean of the University of California School of Public Health, Berkeley, spoke.

Dr. Ruth J. Temple, Community Health Association medical director, announced that the "War on Disease" show at the County Museum in Exposition Park will continue each afternoon for an indefinite period.

Thousands of persons already have visited the show to study exhibits dealing with diphtheria, whooping cough, smallpox, tuberculosis and social diseases.

Annual Stanford Lecture Course—64th Series

The Stanford University School of Medicine announces the Sixty-Fourth Course of Popular Medical Lectures (illustrated) for the year 1946.

Lectures will be given at Lane Hall, on north side of Sacramento Street, near Webster, on Friday evenings. Dates and hours: March 1, March 15, March 29, and April 12, 1946 at eight o'clock sharp.

All interested are cordially invited to attend.

Program

Friday Evening, March 1, 1946

"Poliomyelitis," How It Starts: Harold K. Faber, M.D.

Its Early Treatment: William H. Northway, M.D.

Its Late Treatment: Donald E. King, M.D.

Friday Evening, March 15, 1946

"Surgery of the Heart," Emile F. Holman, M.D.

Friday Evening, March 29, 1946

"The Conquest of Communicable Disease," Russel Van Arsdale Lee, M.D.

Friday Evening, April 12, 1946

"Atomic Energy and Medicine," Robert Stone, M.D.

Thomas de Quincey (1785-1859).—A frail Oxford student of nineteen walked into a London apothecary's shop and purchased a phial of "tincture of laudanum." This was De Quincey's first acquaintance with opium, which had been recommended to him for neuralgia. Besides opium addiction, he suffered from a psychosis, from tuberculosis, and colonic toxins, the result it was believed of copious tea drinking. "The Confessions of an English Opium Eater" is said to have introduced many subsequent addicts to opium, even to the present day.—Warner's *Calendar of Medical History*.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Survey of Hospital Needs in California

A proposed survey of hospital needs of the State, required for the State to qualify for an estimated $1,990,000 annually in Federal construction grants, received favorable recommendation by the Assembly Committee on Public Health, at the special session of the California Legislature.

The survey would be made by an advisory council of 25 persons appointed by the Governor who would work in coöperation with the State Department of Public Health. Sponsor of the measure, Speaker Charles W. Lyon, Beverly Hills, said the Federal funds would be made available for construction and improvements of publicly owned and non-profit private hospitals.

Speaker Lyon said the survey has the backing of the Association of California Hospitals and the California Medical Association.

Hospital Construction Plans Must Be Approved By State Board of Health

Plans for new hospital buildings and for additions or material alterations to existing buildings must be submitted to the State Department of Public Health prior to beginning construction.

This requirement, part of the general regulations for all hospitals was adopted by the State Board of Health at its meeting December 15, 1945, in accordance with powers granted by the 1945 Hospital Licensing Act.

Regulations governing small hospitals (less than 100 beds) large hospitals (100 beds or over) and temporary regulations pending the adoption of minimum fire safety standards for hospitals were also adopted. The regulations were adopted on the recommendation of the Hospital Advisory Committee appointed by the Governor, of which Dr. John Sharp is chairman.

The regulations on submission of the plans provide that "When construction is contemplated, either for new buildings, additions to existing buildings, or material alterations to existing buildings, the preliminary plans shall be submitted in quadruplicate to the State Department of Public Health for approval."

Twenty-three items which must be included in the plans as submitted are specified.

The regulations also provide that, "All proposed new hospital construction or alterations shall meet the standards of the 1943 Uniform Building Code of the Pacific Coast Building Officials Conference and amendments thereto. The standards of the 1943 Uniform Building Code of the Pacific Coast Building Officials Conference, and amendments thereto, shall prevail in the event of conflict with the rules and regulations of the State Board of Public Health, as pertains to new construction of hospitals.

"After the preliminary plans and drawings have been submitted and tentatively approved by the State Department of Public Health, within 10 days of receipt one copy will be returned to the applicant for corrections. The applicant shall then submit, in quadruplicate, blueprints of working drawings and specifications, with the required revisions, to the State Department of Public Health for comparison with the approved preliminary plans, before contract is let, at which time the State Department of Public Health will formally approve the plans or return same for correction, in which case they are to be resubmitted for final approval. The final approved plans shall then be returned within three weeks.

"It is recognized that change orders may be necessary during the course of construction. Telephone or telegraph communication with the State Department of Public

Health is required and approval or rejection will be given within a reasonable time on all change orders affecting the health and/or safety of the patient. This approval will be confirmed in writing by both the architect and the State Department of Public Health."

State Army Hospital to Be Used by Veterans' Administration

The Army Birmingham General Hospital, Van Nuys, turned over 200 beds to the Veterans' Administration on February 11, it was announced by Col. E. K. Wright, deputy administrator for California, Arizona and Nevada.

The hospital will be used for veterans suffering from pulmonary tuberculosis.

An additional 200 beds will be made available within thirty days, it was learned.

Arrangements for use of the hospital were made with the Surgeon General of the Army. It had been originally planned to allocate space for tubercular veterans in the Navy hospital at Corona.

The Navy, however, found itself unable to handle the patients, and arrangements were then made with the Army. The Veterans' Administration will use the beds at the Corona hospital for other cases.

Birmingham Hospital will be staffed by doctors, nurses and other personnel drawn from the Veterans' Hospital at San Fernando and other veteran hospitals in the area.

Los Angeles May Take Over U. S. Hospital in Torrance

Studies of a plan whereby the county government would acquire the Los Angeles Port of Embarkation Hospital at Torrance, built during the war by the Federal government at a cost of several millions of dollars, are to be made by County Manager Wayne R. Allen under orders of the Los Angeles Board of Supervisors.

The hospital, which contains 480 beds, with premises completely fenced, will be closed by the armed forces on March 31 next. If purchased by the county it would become an adjunct to the Los Angeles County General Hospital, which for some time has been crowded to capacity.

The proposal to buy the government institution was presented to the Board of Supervisors by Raymond V. Darby of Inglewood.—Los Angeles *Times*, February 18.

Address on Atomic Outlook Before Annual Meeting of California Hospital in Los Angeles

Application of atomic energy in the field of medicine was discussed on February 1, by Col. Stafford L. Warren, one of the scientists assigned to the atomic bomb project, before the California Hospital medical staff at a dinner meeting at the University Club.

Dr. William H. Olds, chairman of the staff, presided at the session which marked the 25th anniversary of the acquiring of the hospital by the Lutheran Hospital Society of Southern California.

A shortage of hospital facilities, estimated at a minimum of 4,200 beds in the city, was discussed by Ritz E. Heerman, superintendent of the hospital.

Awards were presented to 20 physicians who have served at the hospital more than 25 years, while the staff presented a gold watch to Dr. Benjamin H. Hager, retiring chief of staff.—Los Angeles *Times*, February 2.

Army Will Help Build 80 Veterans' Hospitals

Hundreds of Thousands of Beds Provided in $448,000,000 Two-Year Construction Program.

The Veterans' Administration on February 16, enlisted the aid of the Army Engineers Corps to speed work on 80 new hospitals, estimated to cost $448,000,000.

Gen. Omar N. Bradley, Veterans' Administrator, called it the "largest construction program of its kind in history."

He announced the Army coöperation while detailing measures taken to care for sick and wounded veterans during his first six months as administrator.

General Bradley's outline came on the eve of a meeting of the executive committee of the American Legion at Indianapolis. He had planned to attend, Bradley said, but changed his mind when John Stelle, Legion Commander who has been critical of his administration, in an invitation telegram promised him "a most respectful hearing."

"I don't think I should be put on trial by any one group," Bradley commented. "I am responsible only to President Truman."

Two-year Construction

On the hospital work, the Engineers will take over a large part of the construction, and with their help General Bradley said, the job can be completed in 18 to 24 months.

Three of the new hospitals are under construction and funds are available for 47 others. Completion of all will give the Veterans' Administration 183 permanent-type hospitals with 151,500 beds. By 1975 it is estimated 300,000 beds will be required.

Construction of the hospitals costing from $2,500,000 to $10,000,000 each, should not conflict with the Administration's program of 2,700,000 new homes by the end of 1947, Bradley said.

Temporary Measures

Bradley listed these measures to alleviate present and prospective bed shortages pending completion of the hospitals:

The Veterans' Administration has taken over and operates five Army hospitals and has started action to obtain 13 others, including one from the Navy.

The Navy has agreed to give veterans' 9,875 beds in its hospitals and provide staffs. Secretary of War Patterson has agreed to use 10,000 beds in Army hospitals but could not promise to staff all facilities.

Sixty-three medical schools have agreed to supply concultant visiting staffs and residents.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Los Angeles County General Hospital Issues Call for Nurses

With a near-record load of 3,190 patients and prospects for a gradual increase, the nation's largest hospital—Los Angeles County General—on February 14, issued a nation-wide call for more nurses as those on duty continued to work a six-day week.

"We have a dire need for additional nurses," said A. W. Silver, personnel manager at the hospital, "and we are in a position to offer any professional nurse the best in pay, living conditions and opportunity." . . .

Any qualified nurse can file for a graduate nurse's position at the hospital any time she wishes, and to those who are now nursing in any section of the nation who wish to settle in Southern California, the offer presents an unusually attractive picture.

As to housing, for instance:

"If our nurses 'live in' they are given full housing facilities," said Silver. "This includes three meals a day and their personal and uniform laundry.

"They are paid $165 per month for a five-day week, 40 hours per week and no split shifts. This pay does not include their maintenance of $40 per month, however," he said.

There is an attending staff of the finest doctors in the county and the schools of the institution are included for the nurses.

Each nurse is given two weeks' vacation with pay in a centrally-located hospital which is near the beaches, mountains and shopping center. They are given an average of 12 holidays per year with pay, sick benefits and, if a nurse doesn't utilize the 100 per cent of her sick pay or any portion of it, the time is added to her following year's vacation period.

There are no bedside duties, only professional nursing services are required and nurses will be working in the largest county hospital under one roof in the United States and one equipped with the most modern appurtenances. All services are included, such as treatment of psychopathic cases, communicable diseases and tuberculosis.

The hospital's present nursing staff of 332, far below the need of 872 nurses, necessitates a six-day work week at the present time which cannot be remedied—due to the shortage—until the full complement of 540 additional nurses is secured.

Any professional nurse can apply for a position at the hospital at the Civil Service Commission, 102 Hall of Records Building, or by applying to Silver telegraphically or in person at the personnel office of the institution. Nurse Clark also conducts interviews at her desk in the hospital.

Alameda County Nurses to Seek Pay Raise

Nurses of Alameda County today joined the parade of union groups seeking wage increases and improved working conditions.

The recently organized Nurses' Guild of Alameda County, established within the Alameda County Nurses' Association, has prepared negotiating requests to be presented to the East Bay Hospital conference, consisting of all hospitals of Alameda County.

The requests cover increased salaries for general staff, surgery and delivery room nurses; length of work week; holidays and vacations; sick leave; meals, room and laundry benefits, and a health program. In addition, a revised schedule of fees for private duty nurses has been approved.

Details of the requests will not be made public until the hospital association has been formally notified, Morris Glickfeld, the guild's business agent, said today.

Oakland's public health nurses, affiliated with the C.I.O. State, County and Municipal Workers' Union, earlier opened a drive to secure higher wages and improved working conditions.—Oakland *Post-Enquirer*, January 22.

COMMITTEE ON INDUSTRIAL PRACTICE

California Legislature Enacts Bill to Cover Unemployment Through Illness

The Senate on February 13, gave final passage to the amended Shelley bill providing unemployment disability insurance benefits for 2,600,000 California wage earners and salaried folk covered by the unemployment insurance system. It now goes to the Governor for approval.

Introduced by Senator John F. Shelley of San Francisco, the bill was high on the list of measures urged for adoption by Governor Earl Warren during the "reconversion" special session. It was bitterly opposed by representatives of industrial, business and insurance groups, and was attacked as an opening wedge for compulsory "health insurance."

No New Cost

Payment of benefits caused by unemployment due to accident or illness will not entail added cost upon either employer or employee, according to the Governor, Shelley and other proponents. They have asserted that unless the State uses this money, which is now theoretically in the United States Treasury, the Federal Government is likely to use it as a subsidy to help the unemployment funds of poorer states, especially in the South.

The 1 per cent now deducted from the employees' pay will be placed in a special unemployment compensation disability fund while the employers' contribution will continue to go into the unemployment insurance fund and be sufficient to sustain it. Payment of benefits from the new fund will not begin for eighteen months. . . .
—San Francisco *Examiner*, February 15.

Medical Fees Group Starts Drafting Proposed Schedule

Attempts to secure the adoption of a satisfactory medical fee schedule to apply in postwar compensation cases in California were reported as making considerable progress.

A sub-committee, which is composed of Dr. Lester Newman of the State Compensation Fund, chairman; Richard Quigley of California Casualty Indemnity Exchange, and Dr. Nelson Howard of the California Medical Association have been at work to formulate a definite schedule. The present schedule of the California Medical Association served as the model for the committee and it is expected that the draft as presented by the sub-committee will be scrutinized in detail by the entire group when it is finally presented.

It is reported that California physicians are anxious to include in the postwar schedule the 15 per cent increase over the pre-war fees which is now used in the war emergency program.—San Francisco *Underwriter's Report*.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

American Psychiatric Association Gives Solid Backing to General Bradley in His Program for Psychiatric Care of Veterans, Stating He Has Sought and Acted Upon Best Professional Advice Regardless of Politics

Solid backing of General Omar Bradley, Veterans' Administrator, and Major General Paul R. Hawley, his surgeon-general, came officially today from the American Psychiatric Association, representing all the psychiatrists in the country. General Bradley's policy of locating new veterans' hospitals as near as possible to the great and successful centers of medical care, on the basis of veterans' needs, instead of on the basis of political patronage, was specifically endorsed by the Association through its President, Dr. Karl M. Bowman, Professor of Psychiatry at the University of California, San Francisco, California.

The American Psychiatric Association asserted that the best medical and psychiatric care for the veterans could be provided by the policy as outlined by General Bradley and Major General Hawley, and demanded that nothing be allowed to interfere with the execution of this plan to endanger the best possible scientific care for the veteran.

The official statement of the American Psychiatric Association called attention to the fact that the Veterans' Administration psychiatric facilities had in the past been located through references from chambers of commerce and through political pressure groups who lost sight of the fact that only near the great medical centers could the best veterans' care be developed.

It was pointed out that as a result, there are today numerous small veterans' hospitals in inaccessible places, to which suitable medical and nursing personnel cannot be attached, and which are largely removed from the possibility of consultation with the most progressive medical centers.

"The Veterans' Administration has suffered greatly at the hands of politics, both in Congress and on the outside of Congress," said Dr. Bowman. "It augurs well for the future care of veterans that General Bradley and those directly under him have shown no disposition to yield to such political pressure."

Heralding the new emphasis placed by the Veterans' Administration on the medical needs of the ill veteran, the official statement said "Deans' committees have been set up in many centers to provide consultative service to the existing veterans' hospitals and those to be established. A new salary scale designed to secure the best full-time physicians, as well as consultants, has been provided, and the out-patient service is being rapidly developed and improved. The institutions are again being referred to as hospitals instead of 'facilities,' a change which it is hoped will be followed by the appointment of medical superintendents instead of lay 'managers'."

"The American Psychiatric Association has been greatly pleased with the coöperative attitude of General Bradley and General Hawley in working out plans for the Veterans' Administration to care for psychiatric patients," asserted Dr. Bowman, and he went on to say that General Hawley had consulted with the outstanding psychiatrists of this country in appointing Captain Daniel Blain as head of neuropsychiatric work in the Veterans' Administration, and is satisfactorily backing all specific recommendations to improve the care of psychiatric patients.

Military Clippings.—Some news items of a military nature from the daily press follow:

Army Commends U. C. Hospital Work

Berkeley, March 4.—A certificate of appreciation from the Surgeon General of the Army in praise of the work of the 30th General Hospital, staffed by University of California Medical School faculty members, has been received by President Robert G. Sproul. The 30th General Hospital was in England, France and Belgium.

The certificate states in part: "By its (the University's) patriotic endeavor it unselfishly sponsored, organized and staffed the 30th General Hospital thereby dedicating itself unsparingly to the service of its country. By its experience and skill it reduced the mortality of our troops to a record unequaled by any nation in the annals of war. . . . The service, coöperation and loyalty of this unit, under circumstances never before encountered in the long history of conflicts is worthy of the highest praise and its achievements are an inspiration to all."—U. C. *Clip Sheet,* March 4.

New S. F. Branch Offices Speed Veterans' Program

General Omar N. Bradley's plan of decentralization for operation of the Veterans' Administration should be completed here by August, Col. Edwin K. Wright, acting deputy administrator for California, Nevada, Arizona, Hawaii and the Philippines said today on the opening of new area offices at 49 Fourth St., San Francisco.

Immediate supervision over hospitals, homes, regional and contact offices and the determining of local policy is the function of the branch office. Later, as the decentralization progresses, it will take over pension, insurance and other matters to accelerate services to all veterans in the area, he explained.

Admitting that local operations have been bogged in some instances, he disclosed in January the San Francisco regional V.A. office received more applications from veterans in Northern California for education and training than the total number of all claims it acted upon in the 23-year period between world wars.

Daily the backlogs are being reduced, General Bradley's trouble-shooter said.

Colonel Wright said the decentralization is being carried out as fast as possible with the minimum of disruption. Space limitations and personnel shortages, not fully overcome yet, have hindered operations.

No immediate plans for more V.A. hospitals in this area were foreseen by Colonel Wright, despite a population shift which promises to give California a veteran populace of one and a half million.—San Francisco *News,* February 9.

Military Deaths in World War II

Since the Nazis plunged the world into war with their invasion of Poland in September, 1939, many millions of men have lost their lives in battle. Just how great the military loss of life has been in World War II probably will never be known with great accuracy. For many of the countries there are only vague statements regarding casualties. This applies even to some of the major belligerents. In fact, the United States and the British Empire are the only major powers for which official and fairly complete statements of battle losses are available. Consequently, any figures on the aggregate of military casualties for World War II are at best considered estimates.

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From a review of the published data obtained through a wide variety of sources, some of them conflicting, it is estimated that the combat losses* of the belligerents in World War II are of the order of 9,500,000 to 10,000,000. The actual figure cannot be much less; it may be somewhat higher. Axis losses, estimated conservatively at about 5,200,000, were appreciably greater than those of the United Nations, whose battle toll is estimated to have been in the neighborhood of 4,500,000.

* * *

Germany's military losses, estimated at 3,250,000, have been the heaviest of any country in the war. They were considerably greater than those of Japan, her major Axis partner. It is estimated that the Japanese lost about 1,500,000 men. Italian combat losses were probably 150,000 to 200,000. The aggregate losses for Germany's other satellites are estimated to have been 225,000. Of this total, Rumania's losses account for about 100,000, Hungary's for about 75,000, and Finland's for about 50,000. Bulgaria's losses were insignificant as compared with those of the other Axis countries.

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On the United Nations side, Russian losses were the heaviest by far. They are estimated at approximately 3,000,000, or about two-thirds of the total combat losses suffered by the Allies. The Russian losses are thus estimated to be slightly less than those sustained by Germany. The second highest military toll among the United Nations was borne by the British Empire, whose battle dead are estimated at 375,000 to 400,000. The United States was next in rank among the Allies with respect to battle deaths. The final total of our losses on all fronts of World War II is not yet established. This includes an allowance for deaths among those wounded in action and those still carried as missing on our casualty lists.

The battle deaths of our other European Allies are estimated at nearly 450,000, excluding deaths incurred by forces of the underground. French losses, including those of the Free French, are officially estimated at 167,000, but to this figure may properly be added the many underground fighters among the 100,000 French civilians executed by the Germans between 1940 and 1944. Poland's losses amount to about 125,000 including the deaths in the Polish forces fighting alongside the Allies after the collapse of their country. This excludes fighters of the Polish underground. Death losses of 15,000 to 20,000 were claimed in the battle of Warsaw in 1945. Yugoslavia's toll during her guerilla warfare against the Germans and Italians is estimated to be in the neighborhood of 75,000. Greek losses are estimated at 50,000. The Belgians report over 7,000 combat deaths, the Dutch, more than 6,000 in the five days of fighting in May, 1940, and the Norwegians about 1,000. Deaths of underground fighters in some of these cases exceeded those of men in uniform. China's military deaths since Pearl Harbor are conservatively estimated as 250,000.

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* Unless otherwise stated, the term *losses* throughout this article refers exclusively to deaths in action or from battle wounds in military, naval, or air forces.

Available details regarding British Empire losses are of great interest. Of the nearly 400,000 combat dead, more than 250,000, or two-thirds of the Empire's total, were natives of the United Kingdom. Canada's losses of more than 35,000 were next heaviest. Australia lost over 25,000 men, New Zealand more than 10,000, South Africa about 7,500, and India nearly 30,000. Deaths among fighting men from the other British colonies totaled nearly 10,000 in World War II.

A large part of the death toll in the Empire forces was accounted for by losses among naval and air personnel. The battle deaths in these two branches exceeded 100,000, or more than one-fourth of the Empire's total. British Navy losses were slightly over 50,000, and an additional few thousand men were lost in battle by the naval forces of Canada and Australia. The bomber command of the Royal Air Force lost more than 40,000. Canada's losses in the air made up nearly half, and Australia's about a third of their total deaths in combat.

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The total battle toll in World War II was appreciably greater than that in World War I. Death losses in the earlier conflict are not accurately known, but most of the estimates are of the order of 8,000,000. This is 1,500,000 to 2,000,000 less than the estimated number of 9,500,000 to 10,000,000 for World War II. For the European theater, battle losses in the two World Wars are about equal. In World War I, practically all the estimated 8,000,000 war deaths were sustained in the fight in European territory and in the Atlantic, and only a few thousands elsewhere, whereas in World War II, losses in these areas were about 8,000,000 and losses in the Asiatic and Pacific theaters exceeded 1,500,000 men. During World War I, military deaths were about equally divided between the Eastern and Western fronts in Europe, but in World War II, losses on the Eastern Front, estimated at about 6,000,000, were much the heavier.

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The comparative toll of the two World Wars differs greatly for most of the major belligerents. In some cases it is difficult to make accurate comparisons because the national territories were not identical in the two wars. American losses in World War II were about six times as high as in 1917-1918. Russia's losses in World War II were unquestionably higher than in the earlier conflict, although exact comparison is difficult because Russian armies in the first World War comprised large contingents drawn from a territory forming part of pre-1939 Poland, the Baltic countries, and pre-1939 Rumania. If allowance is made for this, Russian losses in World War II appear to be twice as great as in the earlier conflict. German losses in the war just ended were also much higher than in 1914-1918. Again allowing for differences in area due to boundary changes, World War II losses for Germany are estimated to be about 50 per cent above those of the last war. Because of the radically different nature of the fighting in Western Europe in the two World Wars, British Empire losses in the recent war were less than half those in the earlier conflict This does not apply, however, to naval losses which were appreciably heavier in the recent conflict than in the first World War. For the French, the contrast between the two World Wars is even greater than for the British. In the quick defeat of France in 1940, about 125,000 of her fighting men were killed and subsequent losses among French fighters in various theaters amounted to less than 50,000. Consequently, the total of French losses in World War II was less than one-eighth of that sustained in 1914-1918. Italy's losses likewise were much smaller in the second World War than in the earlier conflict. Probably less than one-third as many Italians were killed in the recent war as in World War I. Rumania and Hungary also lost fewer men than in the earlier war.

* * *

Japan presents by far the most striking contrast with respect to military losses in the two wars. She was actually only a nominal ally in the first war, and her combat losses amounted to a few hundred, incurred in grabbing former German-held territories in Asia and in the Pacific. Consequently, her losses of approximately 1,500,000 soldiers and sailors after Pearl Harbor are incomparably greater than her losses in World War I. A similar contrast exists with respect to China, whose military contribution in the first World War was insignificant, partly because of her military weakness and partly because there was little fighting in Asiatic territories.

* * *

World War II was by far the most destructive in human history in terms of loss of life, both military and civilian, and of damage to social and economic institutions. Recovery from this disaster will be a long and painful process. Dislocations arising from the conflict will plague the world for decades to come. Unless the threat of war is removed in the new atomic age, the prospects are bad indeed for our civilization.—*Statistical Bulletin*, Vol. 27, No. 1, January, 1946.

Veterans Medical Care in California

Medical service on a home-town basis will be provided to eligible veterans soon after February 1 in California. This results from the signing of a contract by the Veterans' Administration and the California Physicians' Service. To General Omar N. Bradley, the able head of the Veterans' Administration, credit is due for adoption of this workable plan.

California already has 1,300,000 ex-service men and women. Of World War II veterans, nearly 70 per cent claim service-connected disabilities. The great majority are not ill or incapacitated enough to require separation from their homes and jobs in veterans' hospitals, but do need the best in medical service as out-patients, and are entitled to it without delay, red tape or personal cost.

California Physicians' Service, whose members will be paid on a fee schedule set up in the government contract, was organized by the California Medical Association. For several years, C.P.S. has provided voluntary, prepaid medical care to civilians desiring the service, and the Veterans' Administration contract broadens its activity considerably.

That the doctors in this State have an organization so they can provide service on a home-town basis, without government regimentation of either the veterans or the medical profession, should prove beneficial to all.—Redlands *Facts*, January 21.

New Medical Plan Ordered For Veterans

New Non-Military Medical Corps to Aid U. S. Veterans

Washington.—(UP.)—General Omar N. Bradley, victor in his first stateside battle, today ordered into operation a complete new deal in medical care for veterans.

Wins Victory

Bradley won his victory late yesterday when President Truman, over protests of the Civil Service commission, signed a bill authorizing an independent, non-military medical corps for Bradley's Veterans' Administration. Bradley said he was setting it up immediately.

He believed the new organization, providing salaries up to $12,000 and higher professional standards, would attract a flood of top rank medical men. The agency is now critically understaffed.

Bradley had ready full page advertisements for insertion in medical journals, advising the profession of new opportunities in veterans' hospitals.

His aides said scores of doctors had already signified their intention to join V.A. as soon as the bill was effective. They have been promised higher pay, a chance at research, and medical standards equal to those of universities.

The president approved the medical department bill against strong advice of civil service, which deplored its abolition of civil service status and elimination of veterans preference.—Merced *Sun-Star*, January 4.

O, America, because you build for mankind I build for you.

—Walt Whitman, *By Blue Ontario's Shore.*

She [America] of the open soul and open door,
With room about her hearth for all mankind!

—J. R. Lowell, *Commemoration Ode.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Headquarters, Hotel Biltmore, 5th and Olive Sts. Dates of meetings: Tuesday, May 7-Friday, May 10, 1946.

American Medical Association. The next annual session of the American Medical Association will be held in San Francisco, July 1-5, 1946. (Monday-Friday, inclusive.)

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in California and Western Medicine for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576. Also, August, 1945, California and Western Medicine, pp. 61-62.) On p. 61 (C.M.A.) and p. 62 (A.M.A.)

Medical Broadcasts*

The Los Angeles County Medical Association:

In March KFAC will present broadcasts on Saturdays at 15:15 a.m.; March 2, 9, 16, 23, and 30.

The Saturday broadcasts of KFI are given at 9:45 a.m., under this title, "The Road to Health."

"Doctors at War":

For radio broadcasts of "Doctors at War" by the American Medical Association, see *J.A.M.A.*

Pharmacological Items of Potential Interest to Clinicians*:

1. *More on Journals:* British Medical Association will publish *British Journal of Pharmacology and Chemotherapy*, edited by J. Gaddum, 4 issues yearly, at 25s. Better get! Current subscriptions and back files of Russian medical journals may be ordered from Mezhdunarodnaja Kniga, Kuznetski most 18, Moskva, U.S.S.R., or from Four Continent Book Corp., 253 5th Ave., New York City, at following prices: *Acta Physicochemica*, $10; *Biochemistry*, $5; *Bulletin Experimental Biology and Medicine*, $5; *Clinical Medicine*, $5; *Hygiene and Sanitation*, $1.30; *Journal Microbiology, Epidemiology and Immunology*, $6; *Medical Parasitology*, $4; *Neuropathology and Psychiatry*, $6; *Ophthalmology*, $6; *Pediatrics*, $5; *Problems of Tuberculosis*, $5; *Problems of Neurosurgery*, $5; *Pharmacology and Toxicology*, $4; *Soviet Medicine*, $5; *Stomatology*, $3, *and Surgery*, $6. *Science* seems to have improved format and policy.

2. *Special Reports:* O.S.R.D. promises 2,500 page report on screening studies on anti-malarials. Office of Medical Information issues O. Temkin's well organized *Report on the Medicinal Treatment of Filariasis Bancrofti* (Nat. Res. Counc., Washington, 1945, 69 pp.). Office of Publication Board, Department of Commerce, issues mimeo series on recent German work: F. J. Curtis & Co., *Pharmaceuticals and Insecticides at I. G. Farben plants Elberfeld & Leverkusen* (Off. Pub. Bd. Rep. P.B. 237, 1945, 127 pp., 75c); A. M. Horack & Co., same title for Hochst am Main (P. B. 241, 38 pp., 25c); K. C. Blanchard, *Evaluation of Antimalarials* (P. B. 246, 20 pp., 25c); I. C. Kleiderer & Co., *Supplementary Report on Elberfeld* (P. B. 248, 141 pp., $1); I. C. Kleiderer & Co., *Pharmaceutical Activities at Hochst am Main* (P. B. 981, 139 pp., 75c).

3. *Enzymes:* S. J. Bach well reviews biological methylation (*Biol. Rev. Cambridge Philosoph. Soc.*, 20:158, 1945). A. L. Lehninger shows activation of fatty acid oxidation is specific function of adenosine triphosphate, sensitive to sulhydryl reagents, requiring free carboxyl group, and diphosphopyridine nucleotide as component of oxidase system (*J. Biol. Chem.*, 161:437, 1945). D. E. Green & Co. discuss transaminases and indicate pyridoxal phosphate as prosthetic group (*Ibid*, p. 559). K. E. Paschkis & Co. observe inhibition of cytochrome oxidase by thiouracil and sulfonamides (*Proc. Soc. Exp. Biol. Med.*, 60:148, 1945).

4. *Cancer:* Thirty reports covering virus approach, carcinogenesis, enzymes, diet and chemotherapy appear in *Cancer Symposium* (A.A.A.S., Smithsonian Bldg., Washington 25, 333 pp., $4). D. T. Thomas discusses mutation of healthy to malignant cell (*Nature* 156:738, Dec. 22, 1945). H. Ulrich warns against danger of leukemia among radiologists (*N. E. J. Med.*, 234:43, Jan. 10, 1945). B. Scharrer describes tumors from nerve section in insects (*Proc. Soc. Exp. Biol. Med.*, 60:184, 1945).

5. *Interesting:* W. Shepard vigorously and intemperately criticizes V. Bush's *Science, the Endless Frontier* and Committee to Support the Bush Plan (*Science*,

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† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week. In California and Western Medicine, some rosters appear in every second or third issue.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

103:65, Jan. 18, 1946). F. D. MacCallum and J. A. R. Miles offer experimental evidence that infective hepatitis is caused by bowel excreted virus (*Lancet* 1:3, Jan. 5, 1946). H. Eagle shows spirochaeticidal action of acid substituted phenyl arsenoxides is influenced by proportion of iron and free acid with undissociated free acid more strongly bound by parasite (*J. Pharmacol. Exp. Therap.*, 85:265, 1945). H. Shay & Co. suggest alkyl sulfates as gastric mucigogues for peptic ulcer (*Science* 103:50, Jan. 11, 1946). E. G. Williams and F. W. Oberst give detailed data on biological and psychological effects in cycle of morphine addiction (*Pub. Health Rep.*, 61:1, Jan. 4, 1946). F. Hawking plasmodia in tissue culture (*Trans Roy Soc. Trop Med. Hyg.*, 39:245, 1945). R. A. Gortner, Jr. & Co. show sugars may increase tooth destroying properties of phosphoric, citric and other acids (*Arch. Biochem.*, 8:405, 1945). J. D. Stone and F. M. Burnet report iodine vapor 0.1 ppm. vol. of air destroys infectivity of influenza virus (*Austral. J. Exp. Biol. Med. Sci.*, 23:205, 1945). G. E. Cartwright & Co. suggest chronic infection anemia due to iron fixation in tissues involving reticulo-endothelial system (*Science*, 103:72, Jan. 18, 1946). A. R. Behnke reviews absorption and elimination of body gases in relation to fat and water content and decompression sickness (*Med.* 24:359, 381, 1945). Our A. Ruskin and P. Rockwell discuss influence of dose and volume on circulation time (*Proc. Soc. Exp. Biol. Med.*, 60:40, 1945). Our E. J. Roth, E. B. Fernadez and G. Drager describe prevention of end-bulb neuromata in painful amputation stumps (*Ibid.*, p. 200). Our A. E. Hansen reviews disturbances of lipid metabolism in children (*Southern Med. J.*, 39:32, 1946).

"Doctors at Home"—N.B.C. Broadcasts

Broadcast by the Independent Radio Stations Affiliated With the NBC Network and the National Broadcasting Company, in Coöperation With the American Medical Association.

"We have chosen the title *Doctors At Home* as an indication of our gratitude for peace and our thankfulness for the return of our greatly missed and much needed family physicians who, in increasing numbers, are laying aside their uniforms to take up the postwar problems at home.

"Among these problems will be the distribution of physicians in response to need, the extension of public health services, the improvement of health in our school children, the maintenance of physical fitness, and the advance of medicine, both preventive and curative.

"*Doctors At Home* will continue to work as they always have, for the two principal purposes of the doctor and the doctor's organization, the American Medical Association. These purposes are the promotion of the science and the art of medicine and the betterment of the public health." Consult local listings for day and time.—W. W. Bauer, M.D., Director, Bureau of Health Education, American Medical Association, 535 N. Dearborn, Chicago.

U. C. and Stanford Will Aid S. F. Veterans' Hospital.—Stanford and California Medical Schools will coöperate with the Veterans' Administration in providing consultants and resident physicians for San Francisco's Veterans' Hospital.

Major General Paul B. Hawley, acting chief medical director of the agency, announced on January 26, a committee from the two schools also will judge professional standards in the hospital.

Members of the committee from Stanford are Drs. Emile F. Holman, chairman; Arthur L. Bloomfield; George S. Johnson and Carleton Mathewson; junior California members are Drs. LeRoy C. Abbott, Karl M. Bowman, William J. Kerr and Howard C. Naffsiger.

Deans of the schools, Dr. L. R. Chandler of Stanford and Dr. Francis S. Smyth of California, are ex-officio committee members.

Fifty of the Nation's 75 Class A medical schools are coöperating in the program throughout the country.

Stanford Medical School Receives Navy Commendations.—Receipt of two Navy commendations for distinguished service by the School of Medicine in educating V-12 stndents during the war, was announced by Donald B. Tresidder, president of the university, on January 28.

One commendation was presented to Dr. Loren R. Chandler, dean of the medical school. The second credited Stanford with an important contribution to "immense expansion" of the Navy medical corps through the training of specially selected enlisted men."

Plans for Coöperation Between Teaching Institutions and Veterans' Hospitals.—The *J.A.M.A.* for Dec. 15, 1945, on page 1100, gave the details of the plans of coöperation between teaching institutions and veterans' hospitals and also for the use of civilian practitioners in the care of the veteran. The description includes the appointments to be given to civilian physicians and the terms of their employment. There appeared also letters that have been sent to the deans of medical colleges, who will be asked to coöperate fully in the development of the plan. Then followed a statement of General Hawley's plan for the immediate future for the staffing of veterans' hospitals and for coöperation with teaching institutions. There will probably have to be some variations made in the plan for individual hospitals according to the necessities, but the plan should work if:

1. Those in charge of administration of hospitals want it to work;

2. There is coöperation between hospitals, medical schools and consultants appointed by the Surgeon General of the Veterans' Administration.

The object of these changes is to give better care to individual patients by bringing into the veterans' hospitals the best trained men obtainable in civilian practice of medicine. This can be done so far as consultants are concerned by putting consultants on a basis which will allow them to devote part of their time to veterans' hospitals and part to their own private practice and teaching.

It is realized by the Surgeon General that it was the complete coöperation of the civilian doctor fitted into his proper sphere of interest and ability in the Army that made the service to the G. I. outstanding in the field of military medicine and surgery. It is planned that this same type of service will be continued in the Veterans' Administration the only difference being that neither the doctor nor the patient will be in uniform.

Red Cross Blood for Civilians.—The American Red Cross will begin on February 3, providing civilians in Los Angeles hospitals with whole blood. It is a service the agency will make without cost to those who need transfusions, hitherto a costly incident to serious illness or injury.

Los Angeles will be the first community in the nation to have this service. As was the case in war years, donations to the Red Cross Blood Bank will be voluntary and without remuneration. Embarking in this service, the Red Cross demonstrates that it can be as useful in peacetime as in war.

At the inception of the program blood will be taken by the Red Cross for exclusive use by the Los Angeles County General Hospital, but ultimately the program embodies supplying of whole blood—typed and tested—to other hospitals, both civilian and military and to physicians in the county. It is a move which carries the indorsement of the Los Angeles County Medical Association.

Hospitals may continue to make a service charge for administering the blood, but the patient will bear no cost for the blood itself.

Members of the community should respond as heartily to this call for assistance to their neighbors at home as they did for their troops overseas.—Editorial in Los Angeles *Times*, February 3.

President Truman Heads New National Foundation to Combat Arthritis.—With President Harry S. Truman as its Honorary Chairman, a new national foundation to combat arthritis was announced on February 10, at a special reception and conference at the Blackstone Hotel in Chicago. Mr. Louis Kranitz, St. Joseph, Missouri, Chairman of the Natitonal Campaign Committee, declared that two and one-half million dollars is the goal being sought for the establishment of the National Arthritis Research Foundation, with its main buildings to be located in Hot Springs National Park, Arkansas.

The Foundation is being established as a national and independent center for studying the causes and treatment of rheumatic diseases.

American Academy of Pediatrics.—Written examination will be under a Monitor, on March 22, 1946. Oral Examination San Francisco, California, at the time of the meeting of the A. M .A. (July 1-5) If sufficient applications are received before March 22 to warrant such an examination. The application fee of this board will be raised to *$100.00* on May 1, 1946.

Public Health League of California: (Northern District) Annual Meeting.—The annual meeting of the Northern District of The Public Health League of California, was held on Wednesday evening, February 20, 1946, at the El Jardin Restaurant, 26 California Street, (near Market), San Francisco. Dinner at 6:30 P. M.

The Nominating Committee submitted the following recommendations for officers of the Northern District: David A. Wood, M.D., San Francisco—President; Compton B. Millarr, D.D.S., San Francisco—Vice-President; Charles A. Noble, Jr., M.D., San Francisco—Secretary; Chester W. Johnson, D.D.S., San Francisco—Treasurer.

Councilors: Kaho Daily, M.D.—Richmond; Ergo A. Majors, M.D.—Oakland; Edmund J. Morrissey, M.D.—San Francisco; Ernest F. Soderstrom, D.D.S.—Modesto; Glendon H. Terwilliger, D.D.S.—Oakland; Frederick T. West, D.D.S.—San Francisco; Paul S. Wyne, M.D.—San Francisco.

Auditor: Robert C. Frates, D.D.S.—San Francisco.

Report on the Special Session of the Legislature was made. Dr. Dwight Murray, Trustee of the A.M.A., reported on the national picture as regards Health Insurance.

War on Disease Show Opened at Los Angeles County Museum on February 17.—Steps the public may take to guard against and eliminate six serious ailments were depicted in displays completed for the "War on Disease Show" in the County Museum, Exposition Park.

The show opened, free to the public, as a feature of Disease Prevention Week, which will continue until the night of Feb. 24. Hours of the exhibit are 10 a.m. to 5 p.m., daily, except Sundays, 1 to 6 p.m., and Monday, 12 noon to 5 p.m.

Disease Charts

Drawings of microbes, graphs on the city's disease rates, explanations of how plagues spread and suggestions on detecting, treating and curing diseases will be displayed in the exhibits. The miracle drug, penicillin, and equipment used in the war on disease also will be shown.

Arranged by the Community Health Association in cooperation with the city and county health departments and other health agencies, the week will be observed with meetings dedicated to curb of whooping cough, smallpox, diphtheria, tuberculosis, syphilis and gonorrhea.

One of the principal civic meetings will be held Wednesday in the Biltmore with Dr. Walter H. Brown, dean, School of Public Health, University of California, Berkeley, as chief speaker.

In many churches, pastors will talk on the benefits of good health today. "February 18" has been named, "phone your doctor day," as men, women and children are urged to arrange for inoculations and physical examinations.—Los Angeles *Times*, February 17.

Northern California Union Health Committee.—The Northern California Union Health Committee was dissolved by action of the Board of Directors. The office closed on February 15, 1946.

Adequate financing had not been provided for continuance of the Committee's activities.

The Board commended the work of the Committee, which resulted from activities sponsored by the California Labor School.

Institutions Accredited by the American Public Health Association to Give the Degree of Master of Public Health (Diploma of Public Health in Canada) for the Academic Year 1946-47.—This list is released by the Executive Board of the American Public Health Association as of January 25, 1946, on recommendation of the Committee on Professional Education, and considers those institutions from which requests for accreditation had been received to that date. Additional applications will be acted upon in due course. In the list of nine schools appears the name:

University of California School of Public Health.

American Public Health Association: 1790 Broadway, New York, N. Y.—The executive board of the American Public Health Association announces the 74th Annual Meeting of the Association to be held in Cleveland, Ohio, the week of November 11, 1946.

This will be the first full-scale convention of this professional society of public health workers since 1942. In 1943 and 1944, streamlined wartime congresses on public health were held and in 1945, for the first time in its history, the organization held no Annual Meeting.

An attendance of 4,000 is anticipated, representing every state in the United States, Canada, South America and many countries outside this hemisphere.

Milk Drinking War Veterans Help Break Dairy Records—Returning veterans drinking milk in record quantities have helped raise United States consumption to all-time high levels, according to the Milk Industry Foundation.

Never in the history of the country has there been such a tremendous flow of milk from American farms to so many people. With milk production on farms around four billion quarts a year higher than before the war, the supply cannot keep up with the demand.

"Milk is our most widely used food," the Foundation says, "and the largest single source of cash farm income. Cash from milk is larger than cattle or hogs, over twice cotton income, wheat or eggs and four times tobacco. Farm income from milk for 1945 is expected to exceed three billion dollars when final figures are compiled.

"Milk and its products comprise more than 25 per cent of the foods estimated to be consumed annually by the average American. Consumers use more than 50 million quarts of fresh milk and cream a day," the Foundation says in its annual statistical review of the industry.

"New methods of distribution efficiency developed during the war are popular and surveys show that the every-other-day distribution plan and other economies save consumers one cent or more per quart. The government's farm subsidy makes possible an additional saving to consumers averaging around 1½ cents a quart."

MILESTONES OF MILK HISTORY

Of Interest to Certified Milk Commissions

1611	Cows arrive for Jamestown Colony.
1624	Cows reach Plymouth Colony.
1841	First regular shipment of milk by rail—Orange County to New York City.
1856	Pasteur experiments start.
1878	Continuous centrifugal cream separator invented by Dr. Gustav De Laval.
1884	Milk bottle invented by Dr. Hervey D. Thatcher, Potsdam, N. Y.
1886	Automatic bottle filler and capper patented.
1890	Tuberculin testing of dairy herds introduced. Dr. S. M. Babcock perfects test for fat content of milk and cream.
1892	Certified milk originated by Dr. Henry L. Coit in Essex County, N. J.
1893	Nathan Straus depots for pasteurized milk open in New York City.
1895	Pasteurizing machines introduced.
1906	Paper single-service container patented.
1908	First compulsory pasteurization law (Chicago) applying to all milk except that from tuberculin tested cows.
1911	Automatic rotary bottle filler and capper perfected.
1914	Tank trucks used for transporting milk.
1924	Insulated milk tank cars introduced.
1932	Methods of increasing Vitamin D in milk made practicable.
1933	Fluid milk included in Army ration.
1938	Textiles made from milk casein.
1942	Wartime milk conservation program inaugurated.

Press Clipipngs.—Some news items from the daily press on matters related to medical practice follow:

What Is Adequate Medical Care?

In a recent address, Dr. Roger I. Lee of Boston, President of the American Medical Association, said: "There have been many clarion shouts that medical care in the United States is inadequate . . . But as far as I know no one has attempted to redefine adequate medical care. . . .

"In 1936 untrained investigators asked people in a house to house survey if they had adequate medical care. If the people said 'No,' they were recorded as having inadequate medical care. Resulting records were broadcast all over the land and were described as indicative of a melancholy state of inadequacy of medical care and of callous neglect by the medical profession.

"More recently there have been highly colored statements regarding the large percentage of rejections for physical defects in connection with the operation of the Selective Service Act. The figures call for careful examination and considered action. Many of the defects have no relation to medical care, adequate or inadequate. Nature does not uniformly produce perfect fruit, be it babies, puppies, calves or apples. If children are very near sighted or astigmatic, adequate medical care demands glasses for the correction; but the Army or the Navy decides whether or not it wants such an individual. . . ."

Dr. Lee points out that the rapid advancement in medical science makes what might be considered adequate medical care today completely out of date and inadequate a year hence. For example, sulfa drugs, penicillin, modern obstetrics and countless other medical developments have made what some might claim adequate or inadequate medical care in 1936 wholly out of date. Furthermore, it is altogether probable that the average individual would be incompetant to state whether or not he had adequate medical care, due to his lack of knowledge of medical progress.

With so much ignorance on such an important subject, it is easy for politically minded reformers to propose plans for socialized medicine which are appealing in their unconscious misrepresentation to an uninformed public.——Mojave *Desert News*, January 17.

U. S. Medical Gains

Chicago, February 14.—(AP.)—Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, declared today American medicine had gone "far beyond" President Truman's recommendations on medical care.

In an address prepared for delivery to the eighty-first annual mid-winter meeting of the Chicago Dental Society, Fishbein listed Truman's health recommendations, and said:

"We have, in fact gone far beyond these recommendations in urging a minimum standard of nutrition, housing, clothing, and recreation as fundamental to good health in any health program."

He added the procedures established for advice to pregnant women and for childbirth care "should be made available to every woman at a price she can afford to pay.

"We have favored suitable hospitalization and medical care for veterans:

"We urge extended, coördinated and intensified research for the advancement of medical science;

"We urge a program of health education with the widest possible dissemination of information regarding the prevention and treatment of disease."

Fishbein said, "all these prosposals are extensions of services now being rendered on a somewhat limited scale since they are not equally available in all parts of the United States," and reported the A.M.A. is preparing a health insurance plan "consistent with the principles of the American plan of government."—Fresno *Call-Bee*, February 14.

Vivisection Called Painless

Chicago.—(AP.)—More pain is inflicted on animals "in one hunting, trapping and fishing season than in all the centuries of animal experimentation," an eminent physiologist declared yesterday. Dr. Anton J. Carlson, University of Chicago distinguished service professor emeritus and temporary chairman of the organizing board of directors of the National Commission for the Protection of Medical Science, said in an address prepared for delivery to the 42nd annual Congress on Medical Education and Licensure "the horrors which anti-vivisectionists portray simply do not exist."

"Much of the 'suffering' alleged in anti-vivisection literature is imaginary," he declared. "Certainly it cannot be immoral to use animals humanely to mitigate human suffering due to disease, as long as we believe animals may be sacrificed for human food and clothing.

"If man is not worth more than the dog, then our efforts to improve man are an error."

Dr. Carlson said many experiments performed on animals result in the mitigation of diseases in man and animals.

"Our efforts toward prevention and control of infantile paralysis would be hopeless, except for the use of some species of monkeys and rodents in detecting and following the polio virus," he said. "And yet, the Anti-Vivisection League of Los Angeles publicly proclaims that 'it does not support the March of Dimes Campaign.'

"When animals under anesthesia are used in medical teaching, they are not allowed to come out of the anesthetic," he added. "Death by anesthesia is certainly not painful."

In another prepared address, Dr. Paul Titus of Pittsburgh, said the two "most pressing" problems of specialized medicine now are "the heavy demands for residency and other training, and the efforts of hospitals to satisfy these demands."—Sacramento *Union*, February 12.

Anesthetics Used in Vivisection

Washington, February 14.—Let those circles which have been agitated over vivisection of dogs take heed—the operations are performed under anesthesia.

A dog in an operating room for experimental purposes receives scientific pain prevention equal to that given a human who comes under the surgical blade.

That goes for cats, too.

A widespread absence of this information has caused dismay among some people who have been reading gruesome accounts of vivisection.

Take it from the Army and from the Friends of Medical Research, New York Academy of Medicine.

Said the Army: "No research capable of inflicting pain or suffering may be undertaken unless the animals are suitably anesthetized, or other steps have been taken to prevent suffering."

Army research is conducted in connection with recognized medical centers. Rules and regulations of the centers govern the Army researchers.

Says the Friends of Medical Research: "There is always anesthesia in an operation on a living creature. The technique for operating on animals is the same as that of operating on people. This applies even to masking every person in the operating room.

"Doctors study dogs to learn about human beings. If conclusions are to be accurate, doctors must provide the same conditions for dogs as they would for persons.

"The law now safeguards all animals used in research. A laboratory dog is prepared for an operation with the care accorded a human being."—San Francisco *News*, February 14.

Forum For Doctors Back From War

"The Economics of Postwar Medical Practice" will be discussed at an open forum for physician veterans, under auspices of the San Francisco Physicians' Forum, Monday at 8 p.m. at Mount Zion Hospital Nurses' Auditorium, 2345 Sutter St.

Major Frank F. Furstenberg will be moderator. The panel of physician veterans will be Drs. Cabot Brown, Garnett Cheney and Roy Cohn.

Topics under discussion will include group practices, settling in rural areas in California, hospital insurance, and health insurance. All physicians are invited to attend. —San Francisco *News*, January 25.

Former Stirling City Physician, 95, Plans to Resume Practice

Stirling City (Butte County, California.)—January 24. —Dr. A. L. Derbyshire, 95, a resident here for many years, has informed local friends he has returned to San Diego from a hospital in Daly City and expects to resume his practice soon.

Dr. Derbyshire will observe his ninety-sixth birthday on Memorial Day. While here he was physician for the Diamond Match Company.—Sacramento *Bee*, January 24.

California "Physicians and Surgeons' Licenses"

Formulating plans for a comprehensive educational program to acquaint the public with the necessity of reading carefully any health insurance or sickness benefit policy before signing it, osteopathic physicians and surgeons from Kern, Tulare and Fresno counties met in Bakersfield February 3, at the Bakersfield Inn. . . .

Following statement was issued:

Many persons are not aware that in California the physician and surgeon certificate is issued as well to doctors of osteopathy (D. O.) as to doctors of medicine (M. D.). Doctors holding the M. D. degree may be graduates of an allopathic, electric or homeopathic school of medicine. Doctors holding the D. O. degree are graduates of an osteopathic school of medicine. The broadest license, entitling the holder to use any and all methods, including medicine and surgery, in the treatment of disease, injuries and deformities, is the physician and surgeon certificate, issued under the provisions of the Business and Professions Code of the State of California. Graduates of any of the above schools who comply with the educational requirements of the Business and Professions Code are eligible to take the examination for the physician and surgeon certificate.—Bakersfield *Californian*, February 4.

MEDICAL JURISPRUDENCE†

Hartley F. Peart, Esq.
San Francisco

Malpractice: Sufficiency of Evidence; Degree of Skill Required of a Surgeon

A recent case decided by the Supreme Court of the State of Washington may be of interest to members of the medical profession because it involved a detailed consideration of the medical procedures and surgical techniques which were employed during an operation, in order to determine whether or not the operating surgeon had been negligent. The surgeon was absolved of any liability.

In *Fritz v. Horsfall*, 163 Pac. (2d) 148; November 1, 1945, the Washington Supreme Court was presented with the following situation. Mr. F. had contacted Dr. H. in 1943, at which time he complained of heartburn. Dr. H. took x-ray pictures of Mr. F. and advised an operation to remove the appendix and gall bladder. The operation was performed on March 9, 1943, after which the patient remained in the hospital until March 30, at which time he returned to his home in the care of a nurse. While at home the wound discharged bile and at one time during the first part of May, a piece of gauze was pulled from the wound by the patient's mother. The wound continued to discharge until the month of July. During that period of time, the patient suffered from fever and chills, and also coughed and vomited blood and bile.

Dr. H. continued to treat the patient and opened the wound on several occasions, after which the patient stated that he felt better. Thereafter until December 3, 1943, Mr. F. was continuously treated by Dr. H. and returned to the hospital in August for a second operation. During this period Mr. F. was in constant ill health suffering from chill, fever, coughing and great pain when the wound broke open and emitted a quantity of bile and blood. During a conversation with the patient the doctor stated, in speaking of other doctors: "They told me I made a slip"; and then said: "Now, listen, you know that any man can make a slip, but I know I didn't."

On December 3, 1943, Mr. F. traveled to the Mayo Clinic at Rochester, Minnesota, where an operation was performed on him about the middle of December by a member of the staff. A post operation was performed and he was discharged on January 19, 1944, and returned to his home in Seattle. Thereafter Mr. F. made a total of three trips to the Mayo Clinic but continued to suffer constantly from jaundice, fever, chills and infection.

After his return from his last trip to the Mayo Clinic, Mr. F. had a conversation with Dr. H. in which he told the doctor that he had been compelled to go to the Mayo Cliinc which cost him "considerable money," and that he felt that Dr. H. would help him; that the doctor replied, "I fully agree with you." Later, when Mr. F. called the doctor, Mr. F. was told that he (the doctor) had done nothing wrong.

Succinctly stated, the foregoing facts formed the background for the malpractice suit which Mr. F. filed against Dr. H. The basis of the suit being, in substance, that Dr. H. had not cured Mr. F. and therefore should be liable for negligence in treating and operating upon Mr. F.

Dr. H.'s testimony is reproduced in the opinion in full, and indicates that he was examined and cross-examined in order to reveal the exact condition of Mr. F.'s gall bladder and the surgical techniques which he employed during the operation. All this with the purpose of determining whether or not he had been negligent.

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† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

The Court first announced the general rule of law that, an individual licensed to practice medicine is presumed to possess that degree of skill and learning which is possessed by the average member of the profession in the community in which he practices, and to have applied that skill and learning with ordinary and reasonable care to those who come to him for treatment. Further, that before a physician or surgeon can be held liable for malpractice he must have done something in the treatment of his patient which the recognized standard of medical practice in his community forbids in such cases or he must have neglected to do something required by those standards. Then the court stated the principle upon which the instant case turned; that it is not required that physicians and surgeons guarantee results, nor that the result be what is desired.

Dr. H. then explained with the aid of intricate diagrams and drawings exactly what transpired during the first operation. First he exposed the gall bladder in order to determine whether or not his diagnosis of a diseased gall bladder was correct. Having confirmed this diagnosis, Dr. H. then continued the operation and during the course of the trial and his testimony related to the Court all his acts and reasons therefor.

It was necessary for the witnesses to explain in minute detail all that occurred during the difficult operation because Mr. F., the patient, had alleged that sometime during the surgery Dr. H. had been negligent and as a result Mr. F. had not been cured.

After a parade of expert witnesses both for and against Mr. F., the Washington Supreme Court held in favor of Dr. H.

In holding for Dr. H. the Court stated Mr. F.'s condition following the operation had been due to infection and not to any mistake or carelessness on the part of Dr. H.; that on the other hand, Dr. H. had used great care in performing the operation and administering to his patient's needs after the operation.

Applying the rule that it is not required that physicians and surgeons guarantee results, nor that the result be what is desired, the Washington Supreme Court held that Dr. H. had fulfilled all his obligations; also, that he possessed that degree of skill and learning possessed by the average member of the profession in the community and that in the instant case he had applied that skill and learning with ordinary and reasonable care to Mr. F.

Whereupon the Washington Supreme Court instructed the lower court to dismiss the action.

Roentgenography and Tuberculosis

Case finding among symptomatic patients cannot be expected to result in a majority of those patients being discovered at a minimal stage; and contact examination among associates of diagnosed patients, although yielding a high proportion of early cases, is limited in its scope, especially among urban residents. Mass roentgenography would appear to be needed if substantial reduction of cases which are advanced at the time of discovery is to be achieved. Berwyn F. Mattison, M.D., Amer. Jour. P. H., Nov. 1944.

Some people have food, but no appetite; others have an appetite, but no food. I have both. The Lord be praised.
—Oliver Cromwell, *Grace.* (attr.)

To make our appetites more keen,
With eager compounds we our palates urge.
—Shakespeare, *Sonnets.* No. cxviii.

Birth Rates—In Relation to Social Factors

Among women of ages 15 to 49 who at the time of the 1940 census were living with their husbands, but had been married more than once, there were 403 children under 5 years of age per 1,000. Thus, as one consequence of the period of separation between marriages, these women had about 16 per cent fewer children than those whose first marriage had not been broken by the time of the census.

In the case of married women whose husbands were absent from the home for temporary or permanent reasons, the ratio of children under 5 years per 1,000 was just half of that for women married once and with their husbands present. The absence of the husband may be through his employment away from home, or because of hospitalization or confinement to prison; there are, in addition, permanent absences, many of which would in due course lead to legal separation or divorce.

Among the widowed or divorced women, there were evidently some who had not long been separated, for in this group there were 208 children under 5 years per 1,000 women of ages 15 to 49. This is considerably less than half the ratio for married women whose first marriage had not terminated.

Apparently, early marital separations are a factor of some significance in the low birth rates usually found in cities. This is made evident by the finding that in urban centers the ratio of children under 5 years per 1,000 women who had ever married—including those who had been widowed, separated, or divorced—is 7.6 per cent less than that for women who were still married and living with their first husband at the time of the census; whereas the corresponding difference in rural farm areas was only 3.3 per cent. This situation reflects the greater frequency of marital separations in the city than in rural sections. Thus, in urban communities, 28 per cent of the native white women of ages 15 to 49 were widowed, divorced, remarried, or separated from their husband, while the corresponding figure for farm areas was only 21 per cent.

Compared with the other geographic areas of the country, the West has not only the lowest ratio of children under 5 years per 1,000 married women, but it also experiences the largest reduction in birth rates as a result of marital separations. Thus, the ratio for all women who had ever married—namely, 412 per 1,000—is 8.4 per cent less than that for women whose first marriage was still enduring in 1940. In this regard, the North Eastern and the North Central States had the smallest loss, about 6 per cent, while for the South it was 6.6 per cent.

Although the frequency of widowhood among women at the child-bearing ages is decreasing, there has for years past been a contrary, upward trend in marital terminations by separation or divorce, tending to reduce the birth rate. If war marriages, and perhaps also immediate postwar marriages, should prove more than ordinarily unstable, this factor may operate in some measure to counteract the otherwise stimulating influence of war conditions upon the birth rate.

R. L. Stevenson (1850-1894).—The last years of Stevenson were spent in Samoa. There he felt better than he had anywhere else during his many years in search of health. Probably, he did more of his writing in sickness than out. He was beloved by his Samoans, and when he lay dying they sat sorrowing around him. Afterwards, they cleared a road up a steep mountainside to his chosen spot on the summit, and there buried the brave soldier who had so long and gallantly fought against tuberculosis.—Warner's *Calendar of Medical History.*

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIX, No. 3, March, 1921

EXCERPTS FROM EDITORIAL NOTES

What Do You Get Out of the State Medical Society?—This is directed straight at YOU, you who are a member of your county society, you who are practicing medicine as a means of making a livelihood, you who are interested in the ideal of medical service, you who have a family to support and a citizen's duty to fulfill. You pay your annual dues and you doubtless wonder what it goes for and what, after all, the county and state medical societies do to justify their existence. Many say they do nothing to justify their existence. For a moment, will you please take exact stock of whether the State society is really worth your dues and what you expect to gain by membership.

The question at the head of this column can be answered thus: You get out of the State Medical Society exactly what and in proportion to what you put into it. It affords you legal protection. It gives you an opportunity for contact with the best of your profession in this and all states. It preserves the standards of your professional practice. It is your agent in the dissemination of health propaganda and preventive medicine. Beyond these things, will you be very candid, and state exactly what else your county and state societies do for you? Will you *then* analyze your answer in the light of what you yourself have done for your county and state societies. You will find that they inevitably strike a balance. If your county society is not alive and worth while to every member, if the state society does not promote the activities you think it ought to promote, if either of them fall short of what YOU think they should do and be, consider well your own part in them and mend your ways. The fault lies exactly with you. The state society is a democratic institution and is governed solely by the votes of the majority. . . .

The Need for Autopsies.—It does not seem to be realized generally how much the progress of medical knowledge and the development of the skill of our practitioners depends upon the possibility of a thorough and yet reverent examination of the dead. . . .

The laity also never seems to realize that each case of disease is a law to itself and is in many essential ways different from each similar case. The average person has an idea that through some obscure, more or less magic process the "doctor" arrives at a *diagnosis* and that, when this wonderful feat has been accomplished, the rest is plain sailing. We ourselves are partly to blame for this impression. . . .

The laity should know that it is inconceivable that a physician should keep his judgment unimpaired without frequently having his opinions checked up at the autopsy-table. . . .

Municipal Tuberculosis Program.—The value to public health and economic welfare of the work of the allied

(Continued from Front Advertising Section, on Page 12)

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† This column, compiled by the undersigned, strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secetary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M.D.
Secretary-Treasurer

Board Proceedings

The Board of Medical Examiners held an oral examination on Saturday and Sunday, January 19th and 20th, in the State Building, Los Angeles, at which one hundred and seventeen (117) applicants presented themselves for examination.

During the year 1945 there were one thousand nine hundred and twenty-six (1,926) applications filed for the various types of certificates issued by the Board of Medical Examiners; of this number one thousand seven hundred and four (1,704) were for physicians and surgeons certificates. The number of applications filed for written examination showed a slight increase over the previous year while the number of reciprocity applicants who based their applications on a license issued by another State, National Board Credentials, or Commissions in the United States Army, Navy, or Public Health Service showed an increase of five hundred and twenty-eight (528), or nearly twice the number filed in 1944.

The number of certificates issued in 1945, of all types, totaled one thousand four hundred and nineteen (1,419); of this number one thousand two hundred and eight were physicians and surgeons certificates. Five hundred and ninety-nine (599) were issued by reciprocity to applicants who based their applications on a license issued by some other State, ninety-eight (98) were issued on National Board Credentials, and eleven were issued on Government Credentials.

On December 31, 1945, there were 641 applications of all classes on file and awaiting final disposition in 1946.

News

"A twelve weeks' refresher course in physchiatry and neurology will be given by the University of California Extension Division under the direction of Dr. Karl M. Bowman. The course will open Monday at the Langley Porter Clinic, San Francisco campus, University of California Medical School. The course is intended particularly for former medical members of the armed forces, who have returned or are about to return to civilian practice." (San Francisco *Call Bulletin*, January 4, 1946.)

"Sentence of 180 days in the county jail, imposed on Neil Zola Garess of La Crescenta on charges to which he pleaded guilty of practicing medicine without a license and of representing himself as a physician, was suspended by Judge Bert P. Woodard in justice court today and the defendant placed on one year's probation and ordered to pay a $100 fine. In imposing sentence, the court ordered Garess to refrain from further practice as a physician. The charges were filed by Maynard C. Youngs for the State Medical Board. Garess is employed as a prescription clerk in a Los Angeles pharmacy." (Glendale *News-Press*, December 14, 1945.)

"J. R. Dieffenbacher, a State department of public

(Continued in Back Advertising Section, on Page 54)

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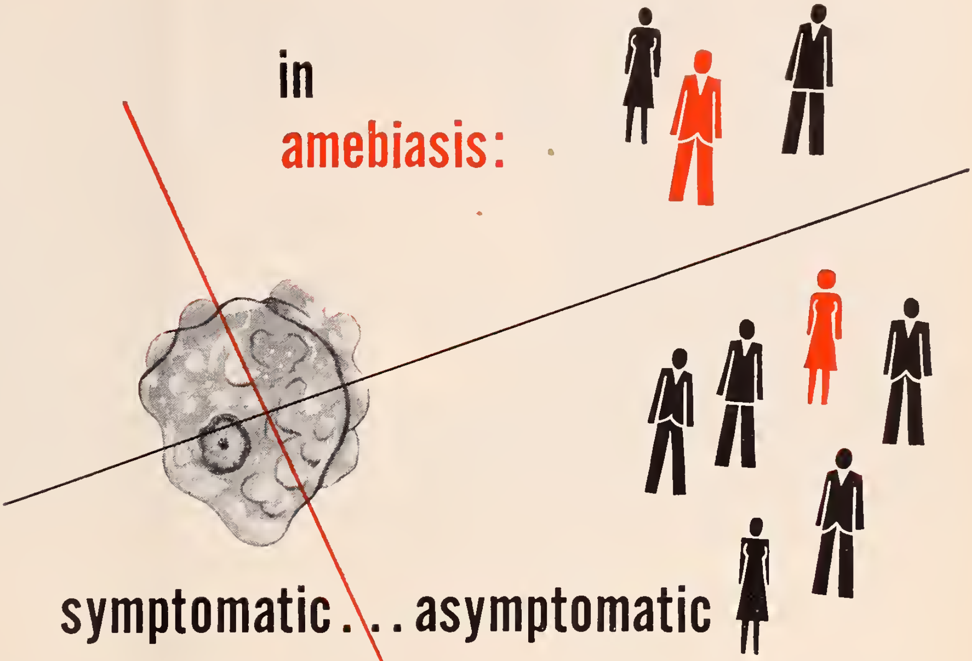
† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

in amebiasis:



symptomatic . . . asymptomatic

Barr[1] states: "... it is just as important to treat properly the symptomless 'carrier' of this parasite as to treat the patient suffering from amebic dysentery."

Stitt, Clough and Clough[2] report, "The disease may be symptomless . . . These mild or symptomless cases have been shown to outnumber greatly the cases with clinical dysentery. They constitute the carriers or 'cyst-passers'."

DIODOQUIN (5, 7-diiodo-8-hydroxyquinoline) is safe to use even in suspected cases of amebiasis. Nonirritating, nontoxic—Diodoquin has been found promptly destructive to protozoa in amebiasis and Trichomonas hominis (intestinalis).

DIODOQUIN

ACCEPTED
AMERICAN MEDICAL ASSN.
Council on Pharmacy and Chemistry

is the registered trademark of G. D. Searle & Co. Chicago 80, Ill.

1. *Barr, D. P.: Modern Medical Therapy in General Practice, 2:1830, Baltimore, Williams & Wilkins Company, 1940.*
2. *Stitt, E. R.; Clough, P. W., and Clough, M. C.: Practical Bacteriology, Haematology and Animal Parasitology, ed. 9, Philadelphia, P. Blakiston's Son & Co., 1938, pp. 410-412.*

SEARLE *Research in the Service of Medicine*

Devereux Schools

Santa Barbara, California — Devon, Pennsylvania

Under the Devereux Foundation

Last spring a group of physicians and parents suggested that a unit of the Devereux Schools be opened on the West Coast.

It was proposed that the new school be patterned educationally after the Devereux Schools at Devon, Pennsylvania, which had so successfully operated for more than a quarter century and had won the support of psychiatrists and pediatricians the country over.

What progress has been made since the preliminary announcement? An organization has been perfected, a delightful property secured at Santa Barbara and the school opened. Now fifty boys and girls, ranging in age from eight to eighteen, are studying here. They are following educational programs, shaped to the needs of each student. Many have superior intelligence, but emotional difficulties that make it hard for them to fit into a standardized school. Others have normal intelligence, but need individualized programs with remedial work in speech, reading, and arithmetic.

Practically all these students were recommended to the school by psychiatrists, pediatricians, or general practitioners who are familiar with the work of the Devereux Schools. One of the fundamental policies of Devereux is to cooperate in every way with the referring physician in his plans for the child.

For further information address —

Helena T. Devereux, Director

Devereux Schools
Santa Barbara, California

Devereux Schools
Devon, Pennsylvania

Las Encinas Sanitarium . . . . Pasadena, California

INTERNAL MEDICINE INCLUDING FUNCTIONAL AND ORGANIC NERVOUS SYSTEM DISEASES

Board of Directors: GEORGE DOCK, M.D., *President;* J. ROBERT SANFORD, M.D., *Vice-President*

Address: STEPHEN SMITH, M.D., F.A.C.P.; CHARLES W. THOMPSON, M.D., F.A.C.P.

Medical Directors, Pasadena, California

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 24)

paper is to classify diseases of the teeth, tonsils and sinuses under one heading, i.e., focal infections of the head. They have a common bacteriology, symptomatology, and cause common systemic disorders. Every examination of the head for focal infections should include all three as being but parts of a single disease.

If we can hold this concept in our minds, our examination will be more thorough, reference to either part implying a consideration of all three. It would be well if we had one term that included all three. . . .

From an Article on "Climacteric Hypertension," by Roland Cummings, M.D., Los Angeles.—The etiology of increased blood pressure is so elusive that every possible lead has been carefully considered and duly followed, it is sad to say, however, with very indifferent results. Of late years owing to the frequency in which a rise of pressure has been noted at the period of the menopause, a common factor in the causation of both the climacteric and hypertension have been and are still being carefully studied. . . .

Excerpt from State Society: Annual Convention Medical Society, State of California, Coronado, Calif., May 10-11, 1921.—The Southern Pacific Company will make reduced rates from points in California on Receipt Certificate Plan, namely, one and one-half fare subject to minimum attendance of 150 paying fare by rail on going trip of one dollar or more. The rates will apply to and from San Diego.

Sale dates on going trip will be May 7 to 11, inclusive, and returning May 11 to 14, 1921, inclusive. . . .

(Continued on Page 40)

AT HOME OR AWAY

SPOT TESTS

SIMPLIFY URINALYSIS

NO TEST TUBES • NO MEASURING • NO BOILING

Diabetics welcome "Spot Tests" (ready to use dry reagents), because of the ease and simplicity in using. No test tubes, no boiling, no measuring; just a little powder, a little urine—color reaction occurs at once if sugar or acetone is present.

Galatest
FOR DETECTION OF SUGAR IN THE URINE

Acetone Test (DENCO)
FOR DETECTION OF ACETONE IN THE URINE

THE SAME SIMPLE TECHNIQUE FOR BOTH

1. A LITTLE POWDER

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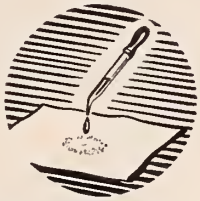

COLOR REACTION IMMEDIATELY

Acetone Test
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A carrying case containing one vial of Acetone Test (Denco) and one vial of Galatest is now available. This is very convenient for the medical bag or for the diabetic patient. The case also contains a medicine dropper and a Galatest color chart. This handy kit or refills of Acetone Test (Denco) and Galatest are obtainable at all prescription pharmacies and surgical supply houses.

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Located near Long Beach on a 15-acre estate, one is unaware of the busy world a few minutes away.

The natural beauty of the grounds and fine recreational facilities aid in bringing contentment and health to those ill and troubled.

***General Conditions Including
Nervous Disorders***

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IS ADVICE HARD FOR PATIENTS TO SWALLOW!

May we suggest, instead, *SMOKE "PHILIP MORRIS"?* Tests* showed 3 out of every 4 cases of smokers' cough cleared on changing to PHILIP MORRIS. Why not observe the results for yourself?

**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

among the guilty
...9 physicians

Nine physicians were among 225 upper income patients found guilty of diets wanting in one or more vitamins. Low-vitamin diets are not restricted by income or by intelligence.[2] Greater assurance of adequate vitamin maintenance is available in potent, easy to take, and reasonably priced Upjohn vitamin preparations.

1. New England J. Med. 228:118 (Jan. 23) 1943.
2. J. A.M.A. 129:613 (Oct. 27) 1945.

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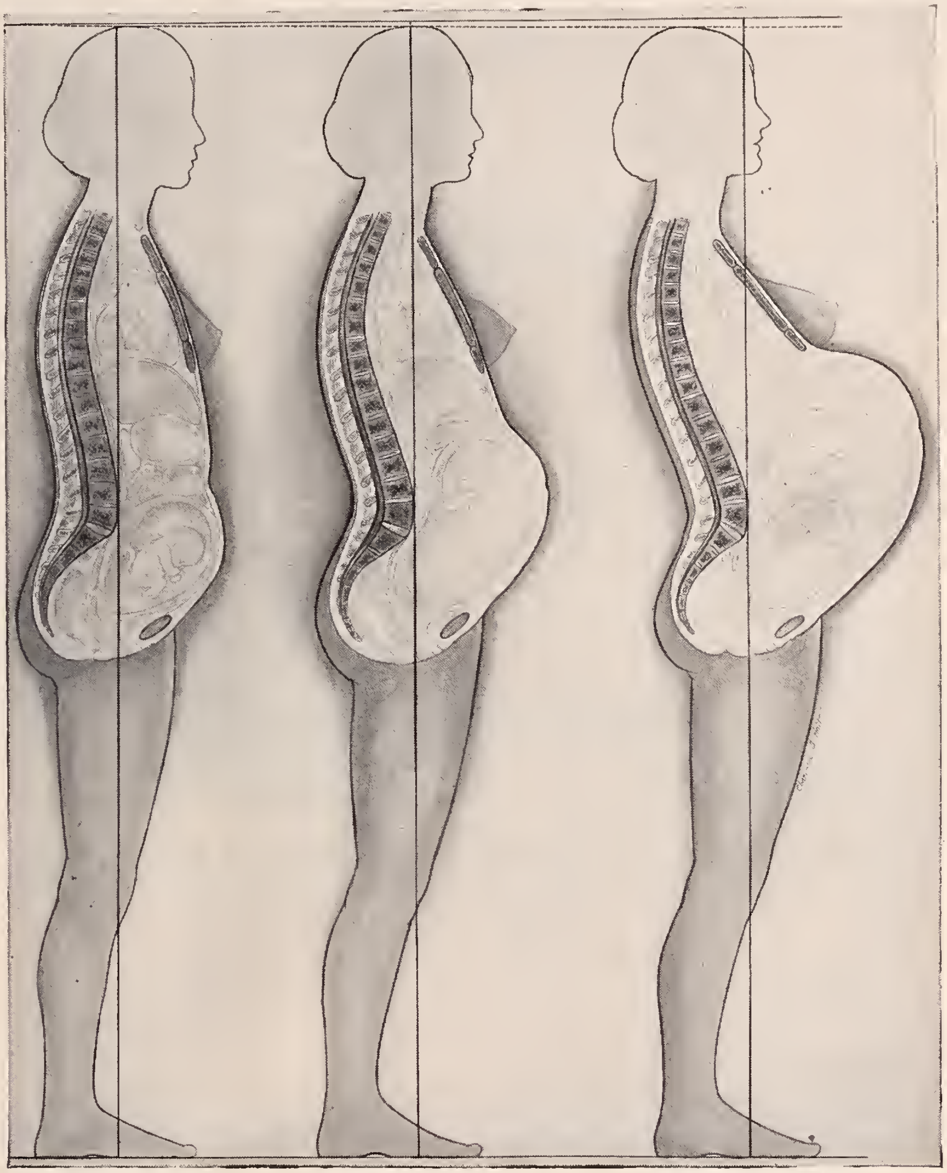
UPJOHN VITAMINS

BODY MECHANICS OF PREGNANCY

• STUDIES FROM LIFE MODELS DURING PREGNANCY • Illustration by Charlotte S. Holt



4 LUNAR MONTHS 7 LUNAR MONTHS 10 LUNAR MONTHS

The postural changes during pregnancy are due to the compensatory backward shift of the center of gravity caused by forward pull of the load of the pregnant uterus.

Note the retracted shoulders, carriage of head (pride of pregnancy), and the accentuation of the natural lumbar lordosis which relieves abnormal tension on back and leg muscles.

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$2,900,000.00 INVESTED ASSETS **$13,000,000.00 PAID FOR CLAIMS**

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Intensive full-time instruction in those subjects which are of particular interest to the physician in general practice. The course covers all branches of Medicine and Surgery.

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TWENTY-FIVE YEARS AGO

(Continued from Page 34)

Excerpts from County Societies:

Los Angeles County: Regular Meeting, January 6, 1921 Re: League for the Conservation of Public Health.—At the Ebell Club House, 18th and S. Figueroa Streets, January 29, 8 p.m., the League held its meeting.

Dr. Granville MacGowan, the president, opened the meeting and asked Dr. Smith to announce the purposes of the Society.

Dr. C. J. Sullivan, the executive secretary, read the annual report of the work done and of the receipts, expenditures and cash on hand. He told of legislation in the matter of Public Health.

Dr. Musgrove spoke interestingly of hospitals as an educational factor.

Dr. John Haynes talked on the proposition of the separate Examining Boards.

Dr. Walter V. Brem urged every member of the County Society to join and follow the leaders, that it is necessary to have concerted action to be effective.

* * *

Fiftieth Anniversary of the Los Angeles County Medical Association.—January 31, at 6:30 in the new Ambassador Hotel, five hundred members of the Medical Society, accompanied by their ladies, celebrated and banqueted to honor Dr. Waltr Lindley, Dr. Joseph Kurtz and Dr. J. P. Widney, the surviving founders of the organization which now numbers eleven hundred.

Dr. Walter V. Brem, the president, welcomed the honored guests and spoke of the medical pioneers in history and of the evolution of medical science.

Dr. W. T. McArthur, as toastmaster, kept his audience in good humor and in bursts of laughter at his sallies of wit. . . .

(Continued on Page 50)

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SIMILAC
A FOOD FOR INFANTS
ACCEPTED AMERICAN MEDICAL ASSN.
M&R DIETETIC LABORATORIES, INC.
COLUMBUS, OHIO.
NET WEIGHT ONE POUND
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For the infant deprived (either wholly or in part) of Mother's Milk

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It gives uniformly good results

• A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil, and fish liver oil concentrate.

One level tablespoonful of the Similac powder added to *two* ounces of water makes 2 fluid ounces of Similac. The caloric value of the mixture is approximately 20 calories per fluid ounce.

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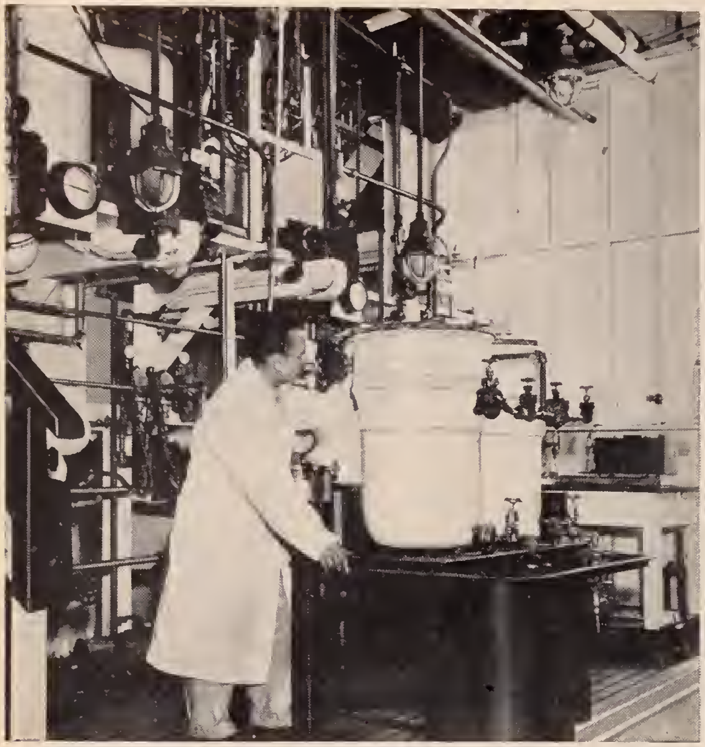

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Penicillin Merck meets the recognized high standard of quality established for all Merck products. It is subjected to repeated tests and control procedures throughout every step of the production process, and the finished product is assayed, tested, and approved under rigid standards established by the Food and Drug Administration and by the Merck Analytical Laboratories.

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IN 1940 Merck research on antibiotics concentrated on Penicillin.

IN 1941 Merck brought about a reciprocal arrangement between British and American investigators to spur the production of Penicillin in co-operation with the United States and British governments.

IN 1942 Merck supplied Penicillin for the first case of bacteriemia successfully treated with this drug in the United States.

IN 1943 Merck sent shipments of Penicillin to England by air transport for urgent therapeutic use by the United States Army Medical Corps.

IN 1944 AND 1945 Merck produced ever-increasing supplies of Penicillin for our Armed Forces.

AND NOW, Merck production of Penicillin has reached a point where, in addition to meeting continuing military requirements, large quantities are being produced for civilian medical needs.

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8 therapeutic hours

Ipral is useful in all types of insomnia. Its gentle action induces sleep gradually and prolongs it for a full six to eight hour period. After what closely resembles a normal night's sleep, the patient awakens generally calm and refreshed. Prescribe one or two tablets of Ipral Calcium (calcium ethylisopropyl barbiturate) *one hour before retiring.* Plain, unmarked, unidentifiable.

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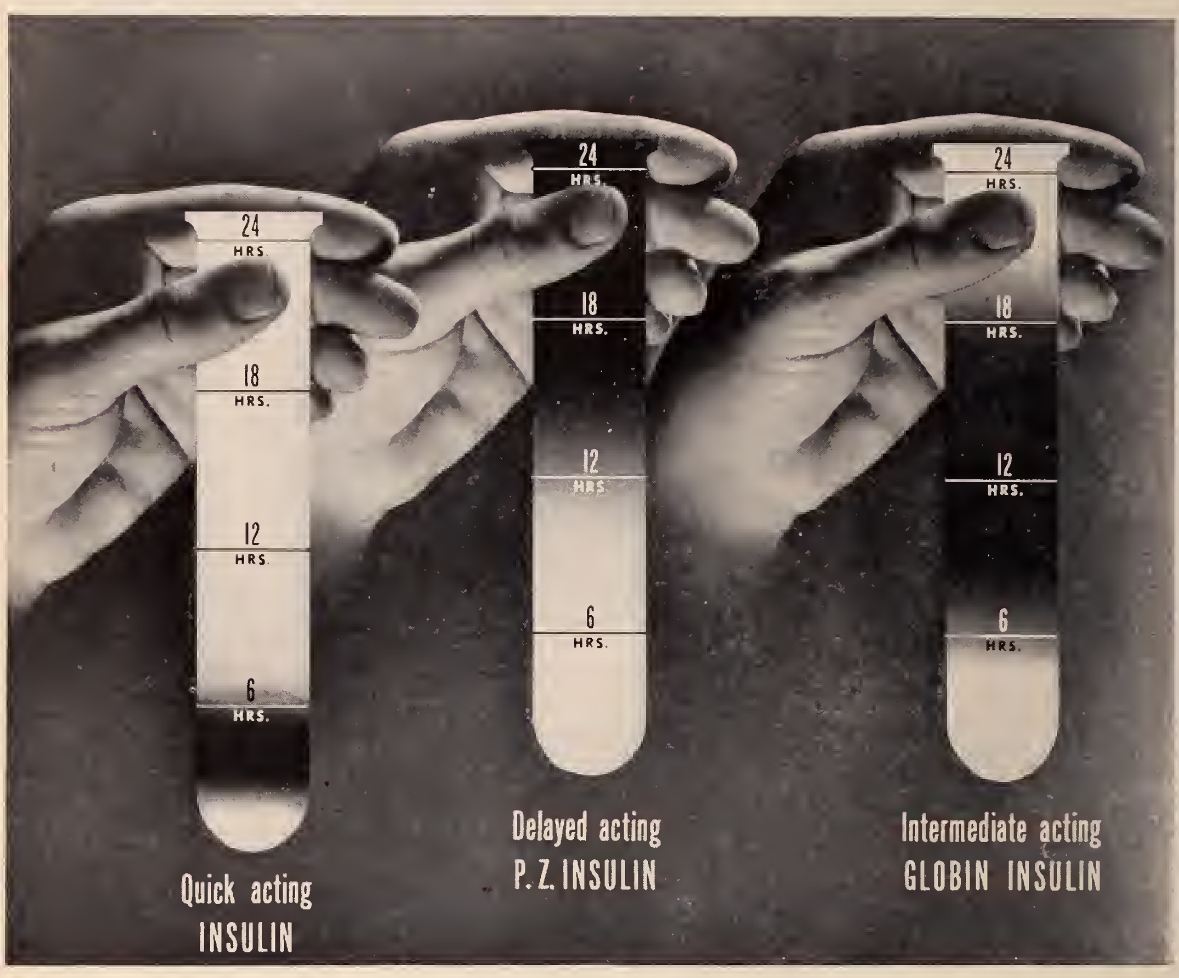
Evolution of the 3rd insulin...



A NEW type of insulin is available for the diabetic—Globin Insulin. First there was a quick-acting but short-lived form. Next came a slow-acting but prolonged type. Now there is the intermediate-acting 'Wellcome' Globin Insulin with Zinc. Activity begins with moderate promptness yet it continues for sixteen or more hours, sufficient to cover the periods of maximum carbohydrate intake. Activity diminishes by night so that nocturnal reactions are minimal.

A single injection daily of 'Wellcome' Globin Insulin with Zinc controls the hyperglycemia of many patients. Physicians are rapidly learning to take advantage of this new third form of insulin when prescribing for their patients.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc. and vials of 10 cc., 40 units in 1 cc. Literature on request. 'Wellcome' trademark registered.

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the norm and standard...

by which all infant antirachitic agents are measured...

... is cod liver oil, the natural vitamin D of which is unsurpassed as a means of prevention or treatment of rickets.

This *ne plus ultra* of antirachitics, together with vitamin A as provided by time-honored cod liver oil, is supplied in three stable convenient, palatable dosage forms by White's Cod Liver Oil Concentrate . . . at a cost-to-patient of *less than a penny a day* for prophylactic antirachitic infant dosage.

In *Liquid* form for drop dosage to infants; *Tablets* for growing children or adults; *Capsules* where larger dosage may be required. Council Accepted. Ethically promoted—not advertised to the laity.

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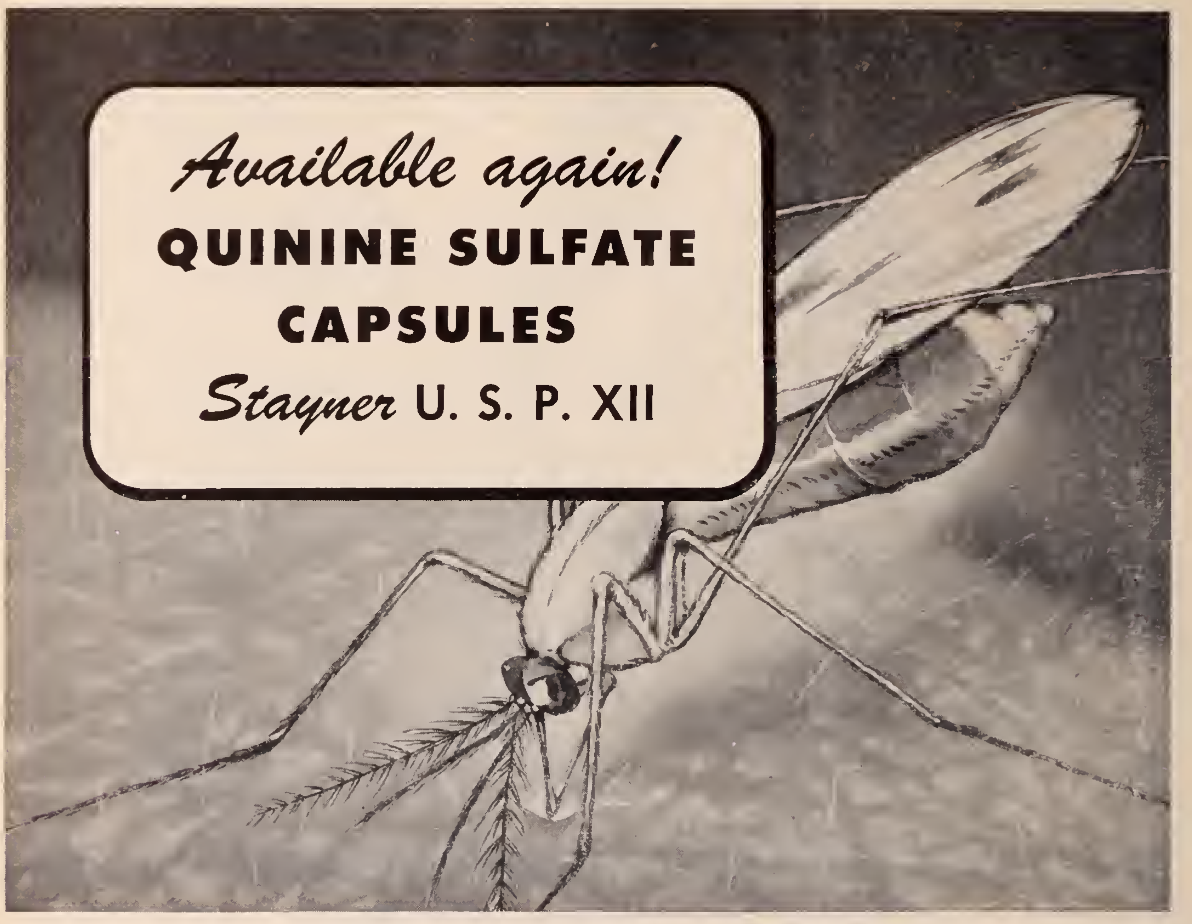
Pharmaceuticals of merit for the physician • New York 13, N. Y. • Windsor, Ont.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Stayner U. S. P. XII

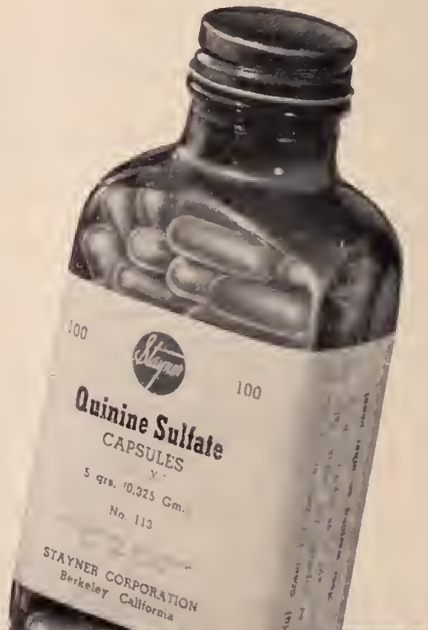
Western pharmacists now have Stayner Quinine Sulfate Capsules

With the return of hundreds of thousands of American veterans from malaria-infested areas, the Federal Government is releasing limited amounts of quinine sulfate for civilian anti-malarial and other essential medicinal needs.

Due to our large capsulating department and central location, Stayner Corporation has been allocated sufficient quantities of Quinine Sulfate U.S.P. to meet the requirements of the Western medical profession.

Quinine Sulfate (Stayner) is now available at pharmacies in 2, 3 and 5 grain capsules. Federal regulations allow it to be dispensed without a written prescription.

Recommended adult dosage for treatment of malaria: 15 to 20 grains daily for seven to ten days, and repeated only upon relapse. (Report of the League of Nations Malaria Commission, 1936.)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In the Schenley Laboratories, the natural process which yields penicillin is safeguarded at *every step* by precision control.

This system of rigid control which characterizes the production of Penicillin Schenley enables you to specify it with the greatest confidence . . . confidence in its purity, its standard potency, and its freedom-from-pyrogens.

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Theocalcin, brand of theobromine-calcium salicylate,
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Available in 7½ grain tablets and in powder form.

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4 color graph on Menstrual Cycle free on request.

TWENTY-FIVE YEARS AGO

(Continued from Page 40)

Hospitals.—Re: Lutheran Hospital.—The California Hospital which was recently purchased by the Lutheran Society was taken over January 10 by Rev. W. S. Dysinger, pastor of the First English Lutheran Church. The price was $350,000. The charity ward will admit persons of any faith.

* * *

Re: Olive View Sanitarium.—The new hospital was opened January 9 to tubercular patients, according to Norman R. Martin, superintendent of the Los Angeles County Hospital. Adults with definite tuberculosis who are ambulant and in the early stage are admitted, also those whose disease can be arrested. They must be citizens unable to pay and must have resided in the county one year. . . .

Excerpt from Obituary: Dr. J. O. Hirschfelder, San Francisco.—Dr. Joseph Oakland Hirschfelder, who died suddenly of heart failure in San Francisco, July 4, 1920, at the age of 65, was a notable figure in the history of medical education in California. . . .

In the reorganization of the faculty of the Medical College of the Pacific into Cooper Medical College, in 1881, at the time of the dedication of the then new college building by Dr. Levi Cooper Lane, Dr. Hirschfelder became Professor of Clinical Medicine, his labors being chiefly at the City and County Hospital of San Francisco. This position he held till Cooper Medical College ceased its activities as an educational institution in 1912, having given over its entire properties and equipment to Stanford University. When Stanford University Medical School was organized and the policy carried out of appointing only younger men Dr. Hirschfelder was made Emeritus Professor of Clinical Medicine and his work as an active teacher ceased. . . .

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Stamina and strength, essential to a joyous, optimistic outlook, are vitally linked to the nutritional status, and will quickly wane if undernutrition is allowed to develop. Zestful living and boundless energy are hardly compatible with nutritional deficiencies.

For the below-par patient whose inadequate nutritional intake is the responsible factor, Ovaltine as a dietary supplement can make a real contribution toward assuring nutritional balance. A good source of high-quality protein, readily utilized carbohydrate, well-emulsified fat, and essential vitamins and minerals, Ovaltine can prove a significant factor in restoring the desired state of optimal nutrition. Three glassfuls daily, made with milk as directed, provide appreciable amounts of essential nutrients as indicated by the table. The low curd tension of Ovaltine assures rapid gastric emptying, hence the appetite for regular meals is not impaired. Ovaltine is enjoyed as a beverage and between meals.

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Ovaltine

Three daily servings of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
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PHOSPHORUS	0.939 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.75 mg.

*Based on average reported values for milk.

IN INFECTIONS COMPLICATING PREGNANCY, DELIVERY, and the PUERPERIUM

ACCUMULATING evidence* points to penicillin as a therapeutic agent of choice not only in puerperal and postabortive sepsis but also against infections complicating pregnancy (when the causative organisms are penicillin-sensitive). Since penicillin crosses the placenta into the fetal circulation, it may affect penicillin-susceptible infection in the fetus.

*Davis, C. H.: Gonorrheal Arthritis Complicating Pregnancy Treated with Penicillin, Am. J. Obst. & Gynec. 50:215 (Aug.) 1945.

Hudson, G. S., and Rucker, M. P.: Gas Bacillus Infection of the Uterus Treated with Penicillin, Am. J. Obst. and Gynec. 50:452 (Oct.) 1945.

Woltz, J. H. E., and Zintel, H. A.: The Transmission of Penicillin to Amniotic Fluid and Fetal Blood in the Human, Am. J. Obst. & Gynec. 50:338 (Sept.) 1945.

Mitchell, R. McN., and Kaminester, S.: Penicillin; Case Report of a Patient Who Recovered from Puerperal Sepsis Hemolytic Streptococcic Septicemia, Am. J. Surg. 63:136 (Jan.) 1944.

White, R. A.: Puerperal Sepsis Treated with Penicillin, Southern M. J. 37:524 (Sept.) 1944.

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These features bespeak the physician's preference for Penicillin-C.S.C.: It is made under rigid laboratory controls which safeguard its potency, sterility, low toxicity, and freedom from pyrogens. The high degree of purification of Penicillin-C.S.C. is indicated by the pale color and small volume of the material in either the 100,000- or 200,000-unit vials. This makes untoward reactions comparatively rare, even when massive dosage and prolonged administration are required.

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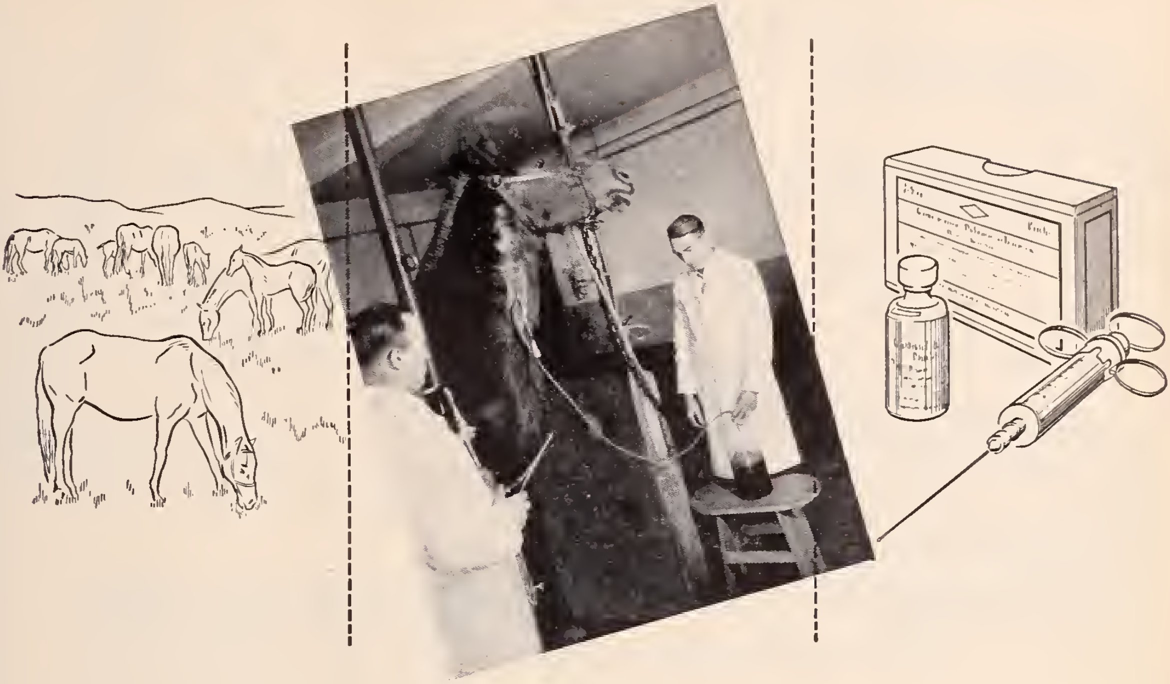

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(Continued from Text Page 164)

health inspector, complained to the police a man pretending to be a physician connected with the department has been calling Sacramentans and asking about their health. Two complaints were received that the spurious agent made telephone calls and in one case he made a personal call. In each instance he represented himself as Dr. Miller or Mueller. Dieffenbacher stated no such person is connected with his department. Dr. Albert F. Zipf, city and county health officer, said no one in his department has been authorized to make such calls." (Sacramento, Sacramento *Bee*, January 19, 1946.)

"Suit by Robert Gaines, an industrial plant worker, against Doctor Harry D. Blunden, resident physician at the General Hospital, charging prolonged hospitalization following an improperly set broken leg, was taken off the Superior Court calendar after an out-of-court $1,000 settlement was made. . . . Gaines was recently awarded a $4,000 judgment from David, Phillipe, driver of a car which ran over him on February 17, of last year, while he lay on the street waiting for medical aid after being hit by another automobile." (Hollywood, *Advertiser*, December 13, 1945.)

"The Assembly today passed a bill to appropriate $7,000,000 for construction of a medical school and medical center at the University of California at Los Angeles. The bill was passed unanimously and sent to the Senate for further consideration after its sponsor declared Los Angeles is the only large city in the United States having no major medical school facilities. . . . (Los Angeles, *Herald and Express*, January 15, 1946.)

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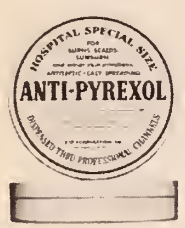

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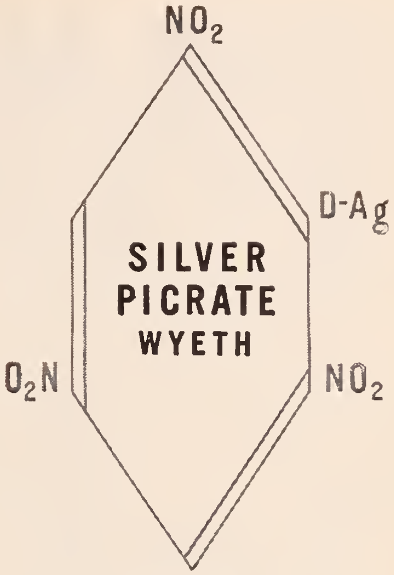

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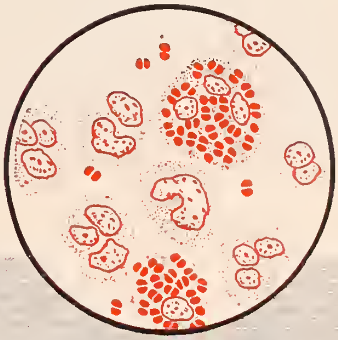

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1. Dickinson, R. L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
2. Eastman, N. J., and Scott, A. B.: Human Fertility 9:33 (June) 1944.
3. Warner, M. P.: J. A. M. A. 115:279 (July 27) 1940.

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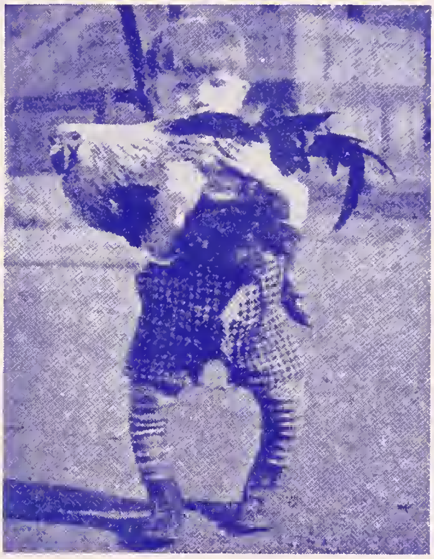

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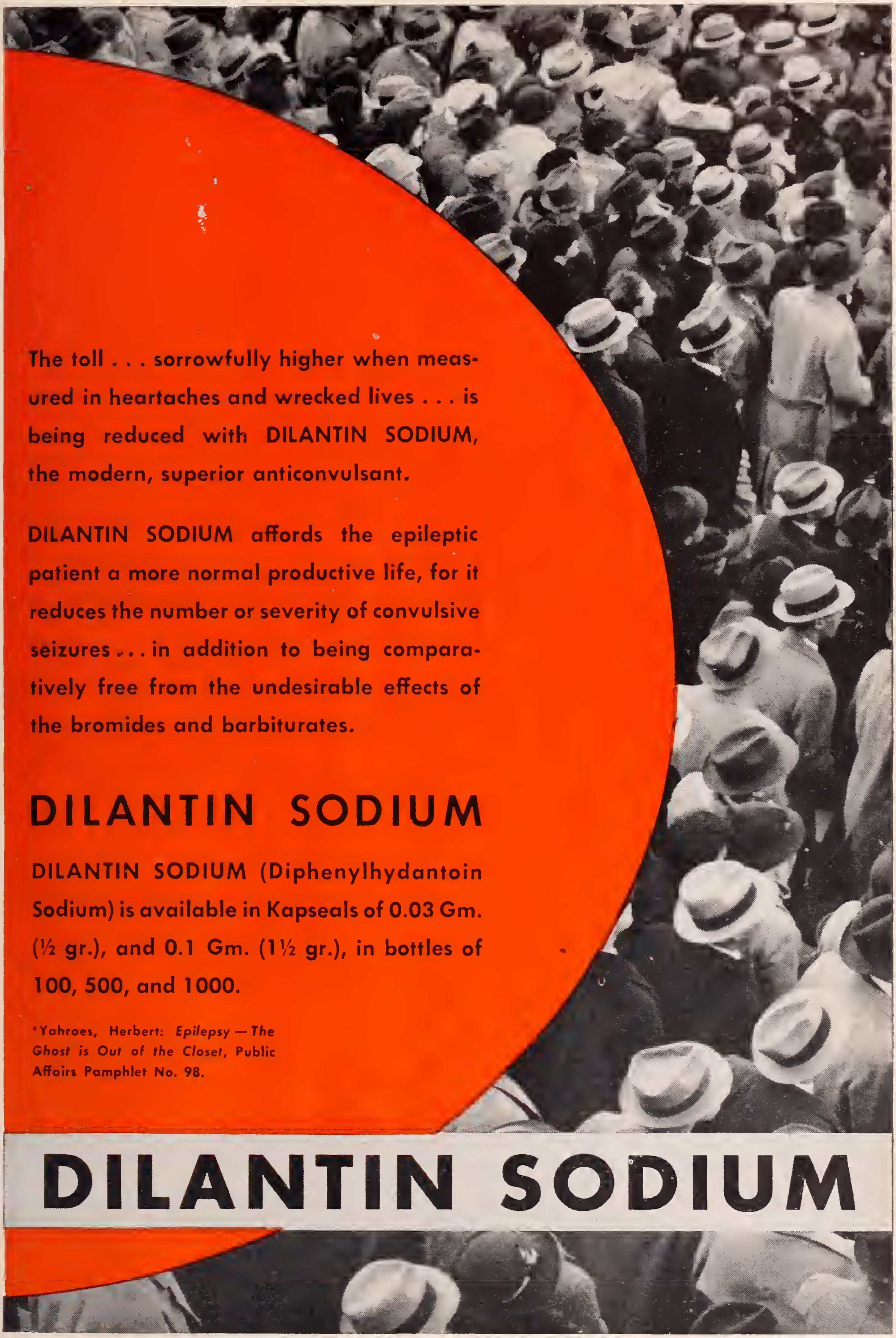

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BOOK REVIEWS

(Continued from Page 7)

who now find themselves faced with unfamiliar problems will be helped in forming a clear mental picture of diseases which they are encountering for the first time.

Detailed instructions for handling these diseases have been issued by the military medical directorates; the methods vary according to the conditions existing in each area so that it is not practicable to include them in a book of this kind. But success in dealing with such diseases depends primarily on early diagnosis which, in turn, is possible only when suspicion of their occurrence has been aroused.

Pediatric X-Ray Diagnosis. A Textbook for Students and Practitioners of Pediatrics, Surgery and Radiology. By John Caffey, A.B., M.D., Associate Professor of Pediatrics, College of Physicians and Surgeons, Columbia University; Associate Pediatrician and Roentgenologist, Babies Hospital and Vanderbilt Clinic, New York City; Consulting Pediatrician, Grasslands Hospital, Westchester County, N. Y., and St. John's Hospital, Yonkers, N. Y. Cloth. Price, $12.50. Pp. 838, illustrated. Chicago: The Year Book Publishers, Inc., 1945.

Within a few weeks after Roentgen announced his now renowned discovery to the world in December, 1895, the x-ray method of examination was applied to infants and children. The Vienna letter of February 29 (M. Rec. 49:312, 1896) contained a roentgen print of the arm of an infant made by Kreidl in Vienna; this is the second reproduction of a roentgen image in the American literature and the first one of pediatric interest. Credit for the first recorded roentgen examination of an infant in the United States belongs to Dr. E. P. Davis of New York City, who described the roentgen shadows cast by the trunk of a living infant and the skull of a dead fetus in March, 1896.

This book stems from the roentgen conferences held

(Continued on Page 14)

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BOOK REVIEWS

(Continued from Page 12)

semimonthly at the Babies Hospital during the last 20 years.

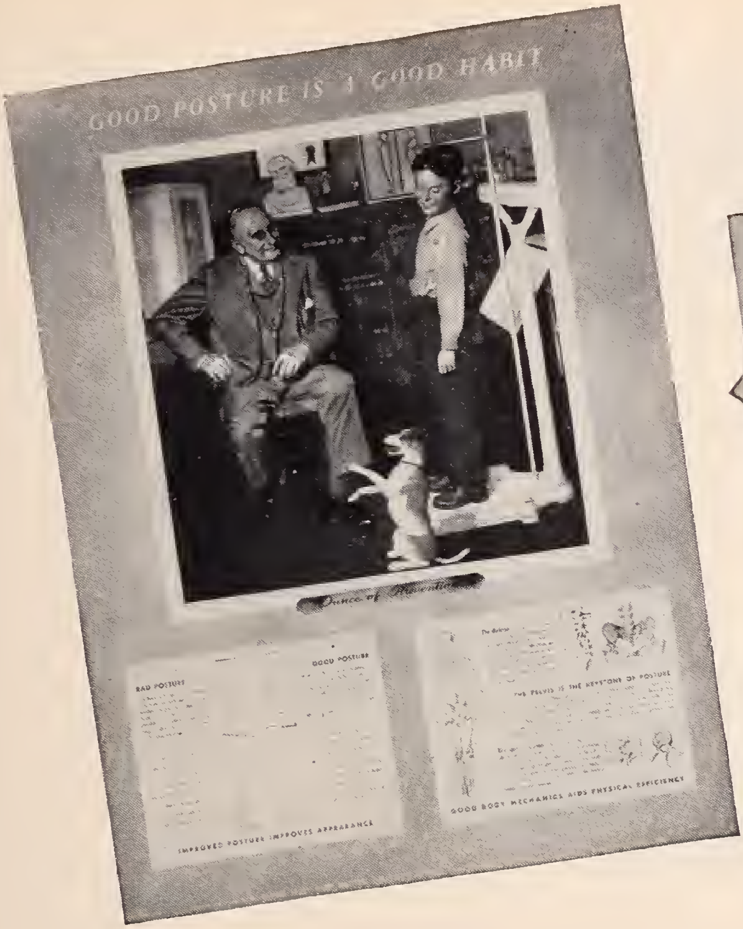
The author states, in the wide and deep field of pediatric diagnosis, selection of the most appropriate material has posed many dilemmas. In the main, data have been chosen which have proved the most useful and instructive in solving the common and important diagnostic problems which have arisen during two decades in a large and busy pediatric hospital and outpatient clinic.

Textbook of Obstetrics. Designed for the Use of Students and Practitioners. By Henricus J. Stander, M.D., F.A.C.S., Professor of Obstetrics and Gynecology, Cornell University Medical College; Obstetrician and Gynecologist-in-Chief, New York Hospital and Director of the Lying-In Hospital, New York City. Stander's third revision: this edition represents the Ninth Edition of *Williams Obstetrics,* the first six of which were written by the late Dr. J. Whitridge Williams, Professor of Obstetrics, Johns Hopkins University School of Medicine; Obstetrician-in-Chief to the Johns Hopkins Hospital, Baltimore, Maryland. Cloth. Price, $10.00 Pp. 1287, with 973 illustrations on 740 figures. New York, London: D. Appleton-Century Company, Incorporated, 1945.

In this textbook, designed for the use of both the medical student and the practitioner, the author states he has attempted to present the science and art of obstetrics as taught in the Cornell University Medical College and practiced in the New York Lying-In-Hospital. Scientific and clinical data are given throughout the text.

This edition presents the ninth edition of Williams' Obstetrics, but as it embodies the teaching and practice of the present author, he should assume full responsibility and thus this change in title is indicated.

(Continued on Page 18)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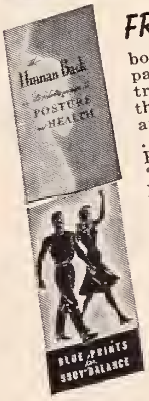
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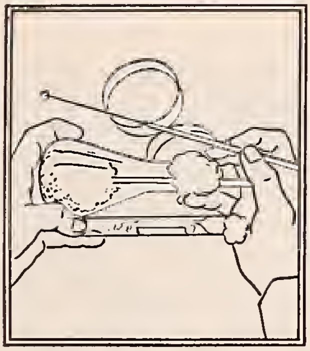

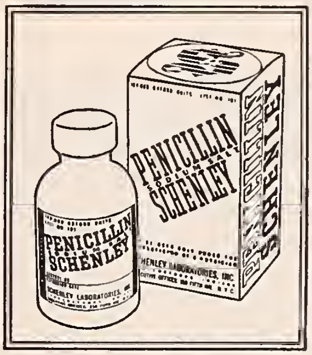

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BOOK REVIEWS

(Continued from Page 14)

One Hundred Years of Gynaecology: 1800-1900. A Comprehensive Review of the Specialty During Its Greatest Century with Summaries and Case Reports of All Diseases Pertaining to Women. By James V. Ricci, A.B., M.D., Clinical Professor of Gynaecology and Obstetrics, New York Medical College; Director of Gynaecology of the City Hospital, New York; Director of Gynaecology and Obstetrics, Columbus Hospital. Attending Gynaecologist and Obstetrician, Flower and Fifth Avenue Hospitals, New York; Consultant in Gynaecology and Obstetrics, Downtown Hospital, New York; Fellow of the New York Academy of Medicine. Department of Gynaecology and Obstetrics of the City Hospital, New York. Cloth. Price, $8.50. Pp. 651. Philadelphia: The Blakiston Company, 1945.

The author states he has attempted to encompass the gynaecological literature of the nineteenth century, and thus bring to a conclusion the historical background of the specialty, beginning at approximately 2000 B.C. and ending with the year 1900. Unlike the companion volume, *The Genealogy of Gynaecology*, this text is not merely an historical document; it is a reference book.

The gynaecological literature of the first half of the nineteenth century is immense; of the latter half, gigantic. The medical library of today is stacked to overflowing with countless reprints, pamphlets, journals and textbooks—an endless number of references, an endless number of contributors. Unfortunately for the compiler, much of this literature is repetitious, imitative and inconsequential. While in the first half of the century, gynaecology was still essentially medical in scope and the bulk of the literature was concerned with clinical and speculative observations, in the latter half, the introduction of embryology, histology, cellular pathology, bacteriology and aseptic surgery enriched and also encumbered the literature with a host of new and strange entities. To sift the material gathered from every country having a medical literature, to select the essentials,

(Continued on Page 20)

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BOOK REVIEWS

(Continued from Page 18)

classify the subject matter, and arrange the contributions chronologically; to ascertain priority in discoveries, and to present this data in a manner suitable for reference was the task the author states he set for himself.

Casualty Work for Advanced First-Aid Students. By A. W. Macquarrie, M.C., Ch.B. (Edin.), Admiralty Surgeon and Agent Civil Defence Medical Officer Major, and Battalion Medical Officer, Home Guard. Cloth. Price, $1.80. Pp. 231, illustrated. Edinburgh: E. & S. Livingstone Ltd., 16-17 Teviot Place, 1944.

Their experiences since the autumn of 1940 have made the British public much more "first-aid minded." Many thousands have qualified under the auspices of the Voluntary Aid Societies and the Fighting Services, and a large proportion are keen to know more of the subject. The author states it is in answer to many such requests that this book has been written. It is intended for those who have already qualified in First Aid, and its teaching is intended to be supplementary to that already received, being based upon the same principles.

Three points are stressed throughout the book. These are the immediate control of hemorrhage, the immobilization of all badly damaged tissues, and rapidity of delivery to the care of the surgeon. There is a tendency among some students to do a "pretty" job at all costs, forgetting that their chief duty is to render the patient safe for his journey to the hospital. When casualties are numerous, "pretty" methods are impossible because time is such an important factor.

The author states that experience during the last three years has resulted in many improved methods of Rescue and First Aid, and as far as possible these have been incorporated. In addition, the subject has been treated from a very much broader point of view than has formerly been the case. It is thus hoped that the whole of the subject-matter will be of interest to every student.

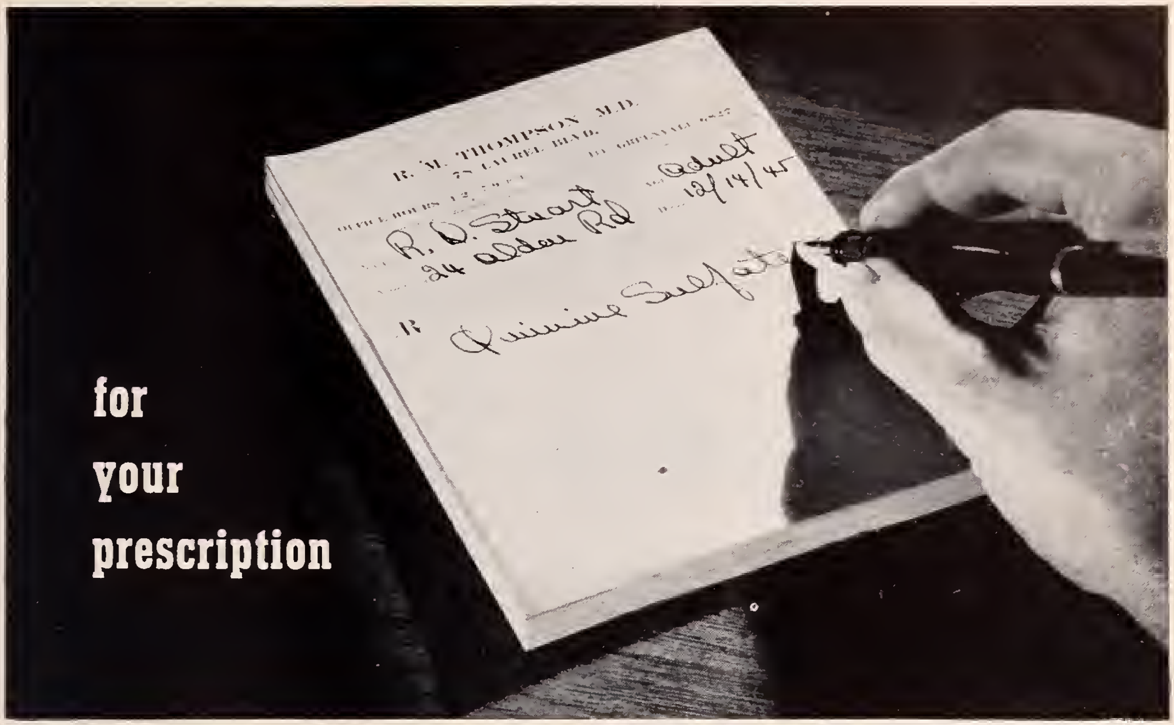
Pulmonary Tuberculosis. A Handbook for Students and Practitioners. By R. Y. Keers, M.D. (Edin.), F.R.F.P.S. (Glas.), Senior Physician and Medical Superintendent, Tor-na-Dee Sanatorium; Late Assistant Medical Superintendent, the British Sanatorium, Montana, Switzerland; First Assistant Medical Officer, King Edward VII Sanatorium, Midhurst; and B. G. Rigden, M.R.C.S. (Eng.), L.R.C.P. (Lond.), First Assistant Medical Officer, Tor-na-Dee Sanatorium; Late Resident Medical Officer, East Anglian Sanatorium, Nayland; Resident Medical Officer, Kelling Sanatorium, Holt, with a Foreword by F. H. Young, O.B.E., M.D. (Camb.), F.R.C.P. (Lond.), D.P.H., Physician, Brompton Hospital for Consumption and Diseases of the Chest; Consulting Physician, Charing Cross Hospital; Medical Officer in Charge of the Tuberculosis Dispensary, St. Bartholomew's Hospital. Cloth. Price, $5.00. Pp. 273, profusely illustrated. A William Wood Book. Baltimore: The Williams and Wilkins Company, 1945.

In presenting this handbook, written primarily for the student and practitioner, the authors make no claim for any originality of method or material. They state they have tried to describe as briefly and as clearly as possible the position of pulmonary tuberculosis today, incorporating the advances in diagnosis and treatment which have occurred in the last two decades.

The practitioner, with scanty leisure for reading, yet harassed by the questions of patients—nowadays more conscious of the significance of pulmonary tuberculosis than ever before—may obtain an outline of present-day therapeutic measures which will enable him to advise and reassure.

So far as possible the more specialized details have been omitted, although in the chapter dealing with Collapse Therapy they have felt that the scope and limita-

(Continued on Page 24)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BOOK REVIEWS

(Continued from Page 20)

tions of each method should be clearly indicated, as this is an aspect of treatment in which most patients are keenly interested and towards which many of their questions are directed.

Essentials of Clinical Allergy. By Samuel J. Taub, M.D., Professor of Medicine, Cook County Graduate School of Medicine; Attending Physician in Medicine, Cook County Hospital; Fellow of the American Academy of Allergy; formerly, Assistant Professor of Medicine, Rush Medical College, of the University of Chicago. Cloth. Price, $3.00. Pp. 198. Baltimore: The Williams & Wilkins Company, 1945.

This is a concise volume designed to clarify the field of allergy for the general practitioner and medical student.

Although the study of the allergic diseases during the past twenty years has resulted in a widespread interest and a broader knowledge by physicians, the rapidly growing literature has become so voluminous and so controversial that the busy general practitioner and medical students are unable to find their way in the maze.

The author states it was his aim to present a practical, clinical approach of the various allergic diseases, as seen in practice. The material has been brought up to date and emphasis stressed on the diagnostic and therapeutic methods used.

The Etiology, Diagnosis and Treatment of Amebiasis. By Charles Franklin Craig, M.D., M.A. (Hon.), F.A.C.S., F.A.C.P., Colonel, United States Army, Retired, D.S.M.; Late Commandant, Army Medical School, and Assistant Commandant, Army Medical Center, Washington, D. C.; Emeritus Professor of Tropical Medicine, Medical School.

(Continued on Page 28)

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Knowledge and skill beyond mere technical competence, experience and judgment, and a sense of *individual responsibility* for unfailing performance, shared by the entire personnel, explain why for more than a quarter of a century U. S. Standard Products have merited the sustained confidence of the medical profession in day-by-day hours at the bedside, and in moments of crisis in the operating theatre.

Building soundly through the years—avoiding the untried and merely spectacular, U. S. Standard Products have developed into a comprehensive list of essentials in general practice and the specialties.

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Perhaps you prefer to make your *own* test. Many doctors do. There is no better way to prove to your own satisfaction the superiority of PHILIP MORRIS.

** Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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Rh NEGATIVE

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Those having the proper blood type will be compensated.

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(The Pioneer Post-Graduate Medical Institution in America)

UROLOGY

A combined full-time course in Urology, covering an academic year (8 months). It comprises instruction in pharmacology; physiology; embryology; viochemistry; bacteriology and pathology; practical work in surgical anatomy and urological operative procedures on the cadaver; regional and general anesthesia (cadaver); office gynecology; proctological diagnosis; the use of the ophthalmoscope; physical diagnosis; roentgenological interpretation; electro-cardiographic interpretation; dermatology and syphilology; neurology; physical therapy; continuous instruction in cystoendoscopic diagnosis and operative instruments manipulation; operative surgical clinics; demonstrations in the operative instrumental management of bladder tumors and other vesical lesions as well as endoscopic prostatic resection.

ANESTHESIA

The course includes general and regional anesthesia, with special demonstrations in the clinics and on the cadaver of caudal, spinal, field blocks, etc. Instruction in intravenous therapy, oxygen therapy, resuscitation, aspiration bronchoscopy.

For Information Address: MEDICAL EXECUTIVE OFFICE, 345 West 50th Street, New York, 19

BOOK REVIEWS

(Continued from Page 24)

Tulane University of Louisiana, New Orleans, La. Cloth. Price, $4.50. Pp. 332, illustrated. Baltimore: The Williams & Wilkins Company, 1944.

At the present time, thousands of our troops are in service in regions where amebiasis is a common and often serious infection, and many of these men will return to the United States infected with *Endamoeba histolytica*, the cause of amebiasis. This will add to the already considerable percentage of infections with this parasite in this country, conservatively estimated at 10 per cent of the population, and will render the diagnosis and proper treatment of the infection of still greater importance from the standpoint of public health.

During the past decade, an enormous amount of research has been accomplished upon almost every phase of amebiasis and in this new book upon the subject it has been the writer's aim to include all the important data accumulated during this period, adding it to the material published in his previous volume.

What People Are: A Study of Normal Young Men. By Clark W. Heath, in collaboration with Lucien Brouha, Lewise W. Gregory, Carl C. Seltzer, Frederic L. Wells, and William L. Woods. The Grant Study, Department of Hygiene, Harvard University. Cloth. Price, $2.00. Pp. 141. Cambridge, Massachusetts: Harvard University Press, 1945.

The fundamental basis for the solution of problems facing the country—problems of education, of jobs for all, of social security, of preparedness for war, etc.—is seldom mentioned in current discussions. Until we know far more than is known today of the nature and needs of those men upon whom fall the work and responsi-

(Continued in Back Advertising Section, Page 36)

no ceiling on growth

Since the age of two sets no ceiling on growth, and since vitamin D is constantly required for optimal absorption of bone-building minerals, continued supplementation well into childhood and adolescence beneficially influences bone structure and height.

Highly potent, convenient, natural Upjohn vitamin D preparations are available in different forms most suitable for infants, children, and adolescents.

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Similar to human milk
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SIMILAC
A FOOD FOR INFANTS
M&R Dietetic Laboratories, Inc.
Columbus, Ohio
Net weight one pound

★The name is never abbreviated; and the product is not like any other infant food—notwithstanding a confusing similarity of names.

The fat of Similac has a physical and chemical composition that permits a fat retention comparable to that of breast milk fat (Holt, Tidwell & Kirk, Acta Pediatrica, Vol. XVI, 1933) . . . In Similac the proteins are rendered soluble to a point approximating the soluble proteins in human milk . . . Similac, like breast milk, has a consistently ZERO curd tension . . . The salt balance of Similac is strikingly like that of human milk (C. W. Martin, M. D., New York State Journal of Medicine, Sept. 1, 1932). *No other substitute resembles breast milk in all of these respects.*

ACCEPTED
AMERICAN MEDICAL ASSN.
Council on Foods

A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil and fish liver oil concentrate.

SIMILAC } SIMILAR TO HUMAN MILK

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Yes, Doctor, our World is SHRINKING!

As we have reduced the time and difficulties of travel to all parts of our global world, organisms long associated with various strange localities have insidiously spread until today we may find so-called "tropical" diseases right in our own backyard.

Amebic dysentery is a major public health problem in our country today.* Epidemics in recent years remove amebic colitis from the tropical or sub-tropical grouping.

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CIBA'S POTENT AMEBACIDE

Free from toxicity or intestinal irritation, VIOFORM is the ideal choice in treating cases where dysentery is clinically evident and in symptomless carriers. Two or more courses, with intermission of one week, are usually advisable. Recommended dose: one tablet (250 mg.) three times daily for ten days.

*Wright, H. E.: Tri-State Medical Journal, July 1939

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of chance

From the selection of crude materials to the analysis of the finished solutions, the manufacture of Lilly Ampoules is under meticulous scientific control. Every detail which will insure the efficacy of the finished product, make it safe, keep it brilliantly clear, and contribute to its permanency is carefully observed. It is never a matter of chance. When ampoule medication is indicated, a Lilly specification guarantees stability, accuracy, and uniformity.

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AND
WESTERN MEDICINE

Official Journal of the California Medical Association
FOUR FIFTY SUTTER, ROOM 2004, SAN FRANCISCO

VOLUME 64
NUMBER 4

APRIL, 1946

50 CENTS A COPY
$5.00 A YEAR

Part I

Annual Session Program

Seventy-fifth Annual Session
Los Angeles, California, May 7-10, 1946

(For Index of Speakers, see Page 199)

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Pre-Convention Program

Reports of Officers and Committees

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SALUTATION FROM PRESIDENT GILMAN

To Members of the California Medical Association—

Greetings:

The 75th annual session of the California Medical Association should stress at least two outstanding events. The first of these is the cessation of hostilities of the second world war, the other the temporary winning of freedom for our profession from government control.

PHILIP K. GILMAN
President, California Medical Association
1946

Special greetings go to the Members of our Association who have so ably served their country in the armed forces. You have sacrificed much and as you lay aside your uniforms you may have the deep and lasting feeling of satisfaction that comes from the consciousness of a job well done.

From private practice to that in the Army and Navy was a difficult adjustment to many if not most of you. The readjustment to civilian surroundings again has been and will be at least as difficult, if not more so for some. With the understanding assistance of your colleagues this transition may well be smoothed and expedited.

To those of you who have borne the heavy burden at home, also well done. You have never faltered in carrying the extra load and have thereby established a record of which we may well be proud.

Our temporary victory to retain in our own hands the method and means of medical care shall not blind us to the fact that the availability of medical care is not sufficiently widespread and complete. Shall government remedy this situation or shall we?

Today we are at the crossroads. We must select the manner in which we believe medicine and surgery should be practiced, and fight for the preservation of that system.

A firmly united profession will enable your officers to follow out the course set down by the House of Delegates. Without such backing your officers will, in spite of the most valiant efforts, of necessity fail.

Fraternally yours,

P. K. GILMAN,

President.

SAM J. McCLENDON
President-Elect

E. VINCENT ASKEY
Speaker of the House of Delegates

JAMES C. McCANN, Guest Speaker
President, Massachusetts Medical Service, Worcester

GEORGE T. PACK, Guest Speaker
Assistant Professor of Clinical Surgery, Cornell University Medical College, N. Y.

ALLAN T. KENYON, Guest Speaker
Assistant Professor of Medicine, School of Medicine, University of Chicago, Chicago

SECTION OFFICERS

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WILLIAM P. KROGER
Chairman, General Surgery

DANIEL G. MORTON
Chairman, Obstetrics and Gynecology

FRANCIS L. CHAMBERLAIN
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EUGENE J. JOERGENSON
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T. FLOYD BELL
Secretary, Obstetrics and Gynecology

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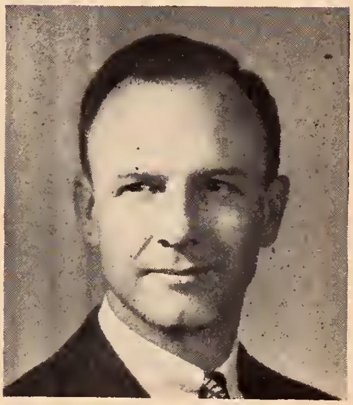
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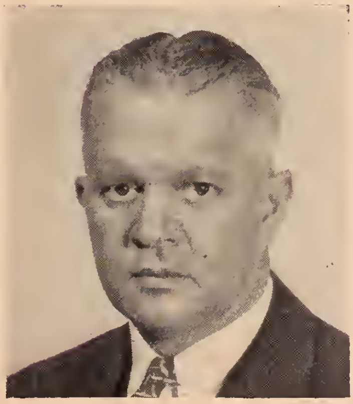
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Chairman, Pathology and Bacteriology

JOHN J. VAN THORNE
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Chairman, Anesthesiology

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Secretary, Anesthesiology

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Chairman, Dermatology and Syphilology

ARTHUR FLETCHER HALL
Secretary, Dermatology and Syphilology

GEORGE M. UHL
Chairman, Public Health

L. A. ALESEN
Vice-Speaker of the House of Delegates

JOHN J. SIPPY
Secretary, Public Health

Part I

PROGRAM

SEVENTY-FIFTH ANNUAL SESSION *of the* CALIFORNIA MEDICAL ASSOCIATION

TO BE HELD AT

THE BILTMORE HOTEL, LOS ANGELES

MAY 7-10, 1946

OFFICERS AND COMMITTEES, 1946

GENERAL OFFICERS*

Philip K. Gilman, San Francisco, President
Sam J. McClendon, San Diego, President-Elect
E. Vincent Askey, Los Angeles, Speaker of House of Delegates
L. A. Alesen, Los Angeles, Vice-Speaker of House of Delegates
Philip K. Gilman, San Francisco, Chairman of Council
George H. Kress, San Francisco, Secretary-Editor
John Hunton, San Francisco, Executive Secretary
Hartley F. Peart, San Francisco, General Counsel

I

MEMBERS OF HOUSE OF DELEGATES — 43rd ANNUAL SESSION

TOTAL DELEGATES (200)

DELEGATES EX OFFICIO (20)

Philip K. Gilman, San Francisco............... President
Sam J. McClendon, San Diego........... President-Elect
E. Vincent Askey, Los Angeles.................... .... Speaker of House of Delegates
L. A. Alesen, Los Angeles.......................... .... Vice-Speaker of House of Delegates
George H. Kress, San Francisco.................. .... Secretary-Treasurer-Editor
Herbert A. Johnston, Anaheim (1947).............. .... Councilor 1st District
Jay J. Crane, Los Angeles (1948).................. .... Councilor 2nd District
Harry E. Henderson, Santa Barbara (1946).......... .... Councilor 3rd District
Axcel E. Anderson, Fresno (1947).. Councilor 4th District
R. Stanley Kneeshaw, San Jose (1948)............ .... Councilor 5th District
John W. Cline, San Francisco (1946).............. .... Councilor 6th District
Lloyd E. Kindall, Oakland (1947).. Councilor 7th District
Frank A. MacDonald, Sacramento (1948)........... .... Councilor 8th District
John W. Green, Vallejo (1946)...... Council 9th District
Walter S. Cherry, Rialto (1948)..... Councilar-at-Large
Edwin L. Bruck, San Francisco (1948). Councilor-at-Large
Shipney J. Shipman, San Francisco (1947)........ .... Councilor-at-Large
E. Earl Moody, Los Angeles (1947)... Councilor-at-Large
Dewey R. Powell, Stockton (1946).... Councilor-at-Large
Edward B. Dewey, Pasadena (1946).. Councilor-at-Large

ELECTED DELEGATES (180)

Alameda County (14)

Delegates	*Alternates*
Warren B. Allen	S. H. Babington
Cyril J. Attwood	A. L. Gleason
Philip J. Dick	John L. Gompertz
William G. Donald	J. B. Graeser
Edward N. Ewer	T. O. Lake
Lester Lawrence	W. K. Lamb
T. C. Lawson	George McClure
Donald D. Lum	Paul P. Michael
Charles J. Lunsford	Roy Nelson
H. Gordon MacLean	George Nesche
Ergo A. Majors	Paul C. Samson
Albert M. Meads	Harold R. Smithies
Ernest W. Page	Maxwell Thebaut
Stanley R. Truman	

Butte-Glenn County (1)

Hollis L. Carey	Lloyd R. Henning

Contra Costa County (2)

Kaho Daily	L. H. Fraser
Harry G. Ford	Solomon N. Weil

Fresno County (4)

V. G. Ghormley	J. M. Arthur
Harry Grayman	O. B. Doyle
H. A. Randel	L. R. Nielson
G. W. Walker	Smith Quimby

Humboldt County (1)

Nathan Wasserman	O. R. Myers

Imperial County (1)

Charles M. Cutshaw	George M. Cole

Inyo-Mono County (1)

Lloyd Bambauer	George Shultz

---

* For Rosters of Councilors, Standing and Special Committees, and Officers of Component County Medical Societies, see in this issue, on advertising pages 2, 4 and 6. Full roster is omitted here, due to lack of space.

Delegates *Alternates*

Kern County (2)

Sophie L. Goldman	Dee Abbott
Juliet Thorner	William H. Moore

Kings County (1)

Lionel Sorenson	W. A. Johnstone

Lassen-Plumas-Modoc County (1)

W. B. McKnight	F. J. Davis, Jr.

Los Angeles County (66)

Eliot Alden	Francis L. Anton
C. Max Anderson	Samuel K. Bacon
Wilbur Bailey	Conrad J. Baumgartner
A. Elmer Belt	Frederick A. Bennetts
Robert L. Belt	Paul C. Blaisdell
Clarence J. Berne	Hans V. Briesen
Peter Blong	William C. Bruff
Lewis P. Bolander	Tenero D. Caruso
Howard W. Bosworth	Rafe C. Chaffin
Richard O. Bullis	Finnis Gaston Cooper
George W. Caldwell	William E. Costolow
John A. Chapman	Roy A. Cummings
Donald A. Charnock	William H. Daniel
John C. Cottrell	Robert C. Donham
Lyle G. Craig	George R. Dunlevy
Lawrence L. Craven	Raoul Esnard
Leonard E. Croft	Ralph A. Ferguson
John W. Crossan	William M. Gibbs
Harold E. Crowe	Robert E. Grogan
Philip J. Cunnane	Lawrence K. Gundrum
J. M. De Los Reyes	Paul M. Hamilton
James C. Doyle	A. M. Hansen
B. R. Dysart	Vernon F. Hauser
Ralph B. Eusden	J. L. Hawkins, Jr.
Franklin Farman	Charles M. Hayes
Alvin G. Foord	Sam S. Herzikoff
Paul D. Foster	J. Severy Hibben
Benjamin Frees	Malcolm R. Hill
Frederick G. Gruber	Paula Horn
Channing W. Hale	Howard P. House
Herman S. Hendrickson	Joseph E. Jensen
Alfred G. Henrich	Clayton R. Johnson
Lawrence M. Hill	William S. Kiskadden
Eugene F. Hoffman	Emma Kittredge
Morrill L. Ilsley	William F. Kroener
Joel S. Kelsey, Jr.	Donald R. Laing
John A. Keys	Anton Laubersheimer
S. G. Kreinman	Ben D. Massey
H. Clifford Loos	Charles F. McCuskey
Harold K. Marshall	Robert J. Moes
Thomas R. Martin	Herbert S. Mooney
Angus C. McDonald	J. C. Negley
Paul E. McMaster	Thomas E. Noble
William R. Molony, Jr.	Frank W. Otto
Clarence M. Movius	John R. Palazzo
Ernest I. Mulder	Ben K. Parks
Carl L. Mulfinger	Fenn E. Poole
George F. Paap	Marcus H. Rabwin
Edward C. Pallette	Clinton A. Roath
F. M. Pottenger, Jr.	John Brady Rogers
William F. Quinn	Carl F. Rusche
Louis J. Regan	Eleanor Seymour
E. T. Remmen	Leroy B. Sherry
Eric A. Royston	Karl P. Stadlinger
Edward S. Ruth	Harvey E. Starr
Roy E. Shipley	William A. Swim
Ralph T. Smith	Raymond W. Swinney
Philip Stephens	Vernon P. Thompson
William Benbow Thompson	Frederick M. Turnbull
Eldon W. Tice	Marie A. Vachout
J. N. Van Meter	Pierre Viole
George D. Wells	Robert A. Walker
Walter Wessels	Carrol L. Weeks
John W. Wilson	Harry J. Wiley
Harold R. Witherbee	Ralph A. Woods
John M. Wright	Angus Wright

Marin County (2)

Carl W. Clark	Ernest W. Denicke
Harold A. Fletcher	Lloyd G. Tyler

Mendocino-Lake County (1)

Lew Knapp Van Allen	Royal Scudder

Merced County (1)

F. O. Lien	E. R. Fountain

Monterey County (2)

Charles Galligan	Harold Duey
Wiley Reeves	W. Rollin Reeves

Napa County (1)

Dwight H. Murray	R. C. Burkett

Delegates *Alternates*

Orange County (3)

John D. Ball	L. J. Hannon
C. Glenn Curtis	Ralph E. Hawes
M. W. Hollingsworth	Charles Irvin

Placer-Nevada-Sierra County (1)

William M. Miller	Max Dunievitz

Riverside County (2)

D. D. Roos	Fred Clark
Omer W. Wheeler	L. J. Clark

Sacramento County (4)

Herbert S. Burden	Carl E. Burkland
Orrin Cook	Dave Dozier
Maurice Hopkins	John L. Fanning
Dudley Saeltzer	Wayne Pollock

San Benito County (1)

Ernest Nelson Moore	Eberle C. Sheldon

San Bernardino County (4)

J. Needham Martin	John L. Nevin
Ray M. Moose	Emmett L. Tisinger
Robert C. Nichols	Arthur E. Varden
E. Wilton Thomas	Thomas I. Zirkle

San Diego County (8)

C. F. Birkenstock	E. G. Crabtree
E. A. Blondin	O. S. Harbaugh
W. H. Geistweit, Jr.	J. C. Holman
George D. Huff	W. L. Martin
Fraser L. Macpherson	L. H. Redelings
A. E. Moore	W. Don Rolph
Bryant R. Simpson	F. M. Smith
John Thorpe Wells	H. C. Torbert

San Francisco County (25)

William L. Bender	Walter Beckh
Howard A. Brown	Donald A. Carson
Edmund Butler	Francis L. Chamberlain
Jesse L. Carr	Leonard G. Dobson
L. R. Chandler	Henry L. Gardner
William C. Deamer	Frank L. A. Gerbode
Martin W. Debenham	W. Wallace Greene
G. Dan Delprat	Keene O. Haldeman
Roberto F. Escamilla	Clyde D. Horner
Frederick A. Fender	George S. Johnson
Frederick S. Foote	Frederick W. Kroll
Kenneth D. Gardner	Charles W. Leach
Leon Goldman	James Clifford Long
Allen T. Hinman	Salvatore P. Lucia
Nelson J. Howard	Clayton G. Lyon
Alson R. Kilgore	Carleton Mathewson, Jr.
John J. Loutzenheiser	M. Laurence Montgomery
Mary E. Mathes	John M. Moore
Charles A. Noble, Jr.	Clayton D. Mote
J. Marion Read	Francis Rochex
William Reilly	William L. Rogers
Daniel W. Sooy	Thomas L. Schulte
H. Brodie Stephens	John F. Skelly
William M. Washburn	Donald R. Smith
Dwight L. Wilbur	Helen B. Weyrauch

San Joaquin County (3)

J. Frank Doughty	C. A. Broaddus
Raymond L. Owens	Albert K. Merchant
G. H. Sanderson	C. M. Webster

San Luis Obispo County (1)

Edward C. Sherman, Jr.	Edward Blair

San Mateo County (3)

Logan Gray	Carl Benninghoven
A. G. Miller	Hartzell Ray
J. Paul Sweeney	

Santa Barbara County (3)

Hugh F. Freidell	Harry C. DeVighne
Charles A. Preuss	Milton J. Geyman
Alfred B. Wilcox	C. W. Henderson

Santa Clara County (5)

C. Kelly Canelo	J. A. Cary
Dell T. Lundquist	Burt Davis
Leslie B. Magoon	Dudley Fagerstrom
John Hunt Shephard	Leon P. Fox
	A. A. Shufelt

Santa Cruz County (1)

Ambrose A. Cowden	Ruth A. Frary

Delegates	*Alternates*
Shasta County (1)	
J. M. Kehoe	H. T. Hinman
Siskiyou County (1)	
J. B. McGuire	C. C. Dickinson
Solano County (2)	
H. Randall Madeley	F. Burton Jones
Felix R. Rossi, Jr.	Carlton C. Purviance
Sonoma County (2)	
Kathleen G. Morris	William N. Makaroff
Wilson Stegeman	Ernest Vieira
Stanislaus County (2)	
J. Azevedo	Julian Edmond
F. R. DeLappe	E. R. McPheeters
Tehama County (1)	
D. E. Thompson	R. G. Frey
Tulare County (2)	
George Keiper	Karl F. Weiss
Charles M. Mathias	Elmo Zumwalt
Ventura County (2)	
G. C. Coffey	R. B. Armitstead
F. A. Shore	C. G. Drace
Yolo County (1)	
John Homer Woolsey	William J. Blevins, Jr.
Yuba-Sutter-Colusa County (1)	
Thomas F. Keyes	Leon Swift

HOUSE OF DELEGATES MEETINGS

43rd ANNUAL SESSION

Special Notice.—The House of Delegates will convene for organization, etc., in the Music Room of the Hotel Biltmore, on Tuesday afternoon, at 4:00 p.m., May 7, 1946. (Music Room is located to the right, on the East-West Galeria, just off the main elevators.)

Adjournment will probably be taken to meet again on Thursday afternoon, at 3:30 p.m., also in the Music Room.

Speaker, E. VINCENT ASKEY, *Los Angeles*
Vice-Speaker, L. A. ALESEN, *Los Angeles*
Secretary, GEORGE H. KRESS, *San Francisco*

AGENDA

FIRST MEETING

Tuesday Afternoon, May 7, 1946, at 4:00 p.m.

Order of Business

1. Call to order.
2. Report of Committee on Credentials, and Organization of the House of Delegates.
   Joseph M. DeLos Reyes, Chairman, Los Angeles; George Huff, San Diego; V. G. Ghormley, Fresno.
3. Roll call.
4. Announcement and approval of Reference Committees.
   (*a*) Committee on Credentials. (Delegates must register with the Committee.)
   (*b*) Reference Committee on the Reports of Officers and Standing Committees (Reference Committee No. 1). Note. Will consider also: Reports of County Society Secretaries.
   (*c*) Reference Committee on the Report of the Council and the Reports of the Secretary-Treasurer and Executive Secretary. (Reference Committee No. 2.)
   (*d*) Reference Committee on Resolutions, Amendments to the Constitution and By-laws, and New and Miscellaneous Business. (Reference Committee No. 3.)
5. Address by President—Philip K. Gilman.
6. Miscellaneous announcements by the Speaker. (Stenographic service, to secure triplicate copies of resolutions, etc.)
7. Report of the Council—Philip K. Gilman, Chairman.
8. Report of the Trustees of the California Medical Association—Philip K. Gilman, President.
9. Report of the Auditing Committee—John W. Cline, Chairman.
10. Report of the Secretary—George H. Kress.
11. Report of the Executive Secretary—John Hunton.
12. Recess.—(Note. At time set (8:30 p.m., on Tuesday) the House of Delegates will recess. Elected and ex-officio members of the House will then convene under the chairmanship of the President of the Board of Trustees of California Physicians' Service, to function with Board of Administrative Members of California Physicians' Service. With the adjournment of the meeting of C.P.S. Administrative members, the C.M.A. House of Delegates will convene, to act again as the House of Delegates of the California Medical Association.)

HOUSE OF DELEGATES RECESS. MEETING OF ADMINISTRATIVE MEMBERS OF CALIFORNIA PHYSICIANS' SERVICE

1. Roll Call (8:30 p.m., on Tuesday).
2. Report of President—Dr. Lowell S. Goin.
3. Report of the Secretary—Dr. Chester L. Cooley.
4. C.P.S. Administration Business Report, by the Executive Director—Mr. W. W. Bowman.
5. Appointment of Nominating Committee for Trustees and Administrative Members at Large.
6. Introduction of Resolutions.
7. Recess—for twenty-four hours. (Time of reconvening will be stated.)
8. Consideration of the Report of the Nominating Committee.
9. Consideration of resolutions.
10. New business.

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13. Report of the Editor—George H. Kress.
14. Reports of District Councilors.
15. Reports of Councilors-at-large.
16. Report of General Counsel—Hartley F. Peart.
17. Reports of Standing and Special Committees:
   A. Standing Committees:
      (*a*) Executive Committee—John W. Cline.
      (*b*) Committee on Associated Societies and Technical Groups—John V. Barrow.
      (*c*) Committee on Audits—John W. Cline.
      (*d*) Committee on Health and Public Instruction—J. C. Geiger.
      (*e*) Committee on History and Obituaries—Morton R. Gibbons, Sr.
      (*f*) Committee on Hospitals, Dispensaries, and Clinics—Clarence E. Rees.
      (*g*) Committee on Industrial Practice — Donald Cass.
      (*h*) Committee on Medical Defense — Nelson J. Howard.
      (*i*) Committee on Medical Economics—H. Gordon MacLean.
      (*j*) Committee on Medical Education and Medical Institutions—B. O. Raulston.
      (*k*) Committee on Organization and Membership—Carl L. Mulfinger.
      (*l*) Committee on Postgraduate Activities—F. E. Clough.
      (*m*) Committee on Publications — George W. Walker.
      (*n*) Committee on Public Policy and Legislation—Dwight H. Murray.
      (*o*) Committee on Scientific Work (Annual Session)—George H. Kress.
      (*p*) Cancer Commission—Lyell C. Kinney.
      (*q*) Editorial Board—Albert J. Scholl.
   B. Special Committees:
      (*a*) Committee on Prepaid Medical and Hospital Care—L. R. Chandler.
      (*b*) Committee on Postwar Planning—Harold A. Fletcher.
      (*c*) California Physicians' Service — Chester L. Cooley.
      (*d*) Delegates to the American Medical Association—Dwight H. Murray.
      (*e*) Physicians' Benevolence Committee—Axcel E. Anderson.
      (*f*) Committee on Participation of the Medical Profession in the War Effort: Procurement and Assignment Service—Harold A. Fletcher.
      (*g*) Advisory Planning Committee—John Hunton.
      (*h*) Committee on A.M.A. Session in San Francisco July 1-5, 1946—John W. Cline.
      (*i*) Committee on Local Arrangements—C.M.A. Annual Session, Los Angeles, May 7-10, 1946—E. T. Remmen.
      (*j*) Liaison Representative to California Veterans' Committee—Frank A. MacDonald.
      (*k*) Advisory Committee to the California Bureau of Vocational Rehabilitation—John W. Cline.
      (*l*) Committee on Maternity-Pediatric Plan of Federal Children's Bureau—Karl L. Schaupp.
      (*m*) Committee to Meet with Representative of Seventeen Midwestern States — Philip K. Gilman.
      (*n*) Committee on Adoption Laws — California State Department of Social Welfare—George H. Kress.
18. Old and Unfinished Business.
   (*a*) Constitutional Amendments.

SECOND MEETING

Thursday, May 9, at 3:30 p.m. In Music Room, off the East-West Galeria

Order of Business

1. Call to order.
2. Supplemental Report of Credentials Committee.
3. Roll Call.
4. Secretary's announcement of Council's selection of place for the 1947 annual session.
5. Election of Officers:
   - (*a*) *President-Elect.*
   - (*b*) *Speaker.*
   - (*c*) *Vice-Speaker.*
   - (*d*) *District Councilors***

     Third District—Harry E. Henderson, Santa Barbara (term expiring).

     Third District—Inyo, Kern, Mono, San Luis Obispo, Santa Barbara and Ventura counties.

     Sixth District—John W. Cline, San Francisco (term expiring).
     Sixth District—San Francisco County.

     Ninth District—John W. Green, Vallejo (term expiring).
     Ninth District—Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma and Trinity counties.
   - (*e*) *Councilors-at-Large:*

     (Note.—*Each vacancy among Councilors-at-Large, Delegates and Alternates is considered in turn. Each vacancy is voted on separately.*)
     Dewey R. Powell, Stockton (term expiring).
     Edward B. Dewey, Pasadena (term expiring).
   - (*f*) *Delegates to the American Medical Association:*

     Delegates are elected for two calendar years. At this session of the C.M.A. House of Delegates, terms of Delegates elected for calendar years 1947-1948 will expire on December 31, 1948.

     For terms: January 1, 1947-December 31, 1948

     Incumbents

     - (*a*) H. Gordon MacLean, Oakland (term expiring).
     - (*b*) E. Vincent Askey, Los Angeles (term expiring).
     - (*c*) John W. Cline, San Francisco (term expiring).
     - (*d*) Donald Cass, Los Angeles (term expiring).
   - (*g*) *Alternates to the American Medical Association:*
     - (*a*) Leopold H. Fraser, Richmond (Alternate to H. Gordon MacLean).
     - (*b*) Donald G. Tollefson, Los Angeles (Alternate to E. Vincent Askey)
     - (*c*) C. Kelly Canelo, San Jose (Alternate to John W. Cline).
     - (*d*) Ralph B. Eusden, Long Beach (Alternate to Donald Cass).
6. Announcement by Secretary.
   Council's nominations of Members of Standing Committees. (For approval by the House of Delegates.)
7. Reports of Reference Committees:
   - (*a*) Report of Conference Committee Number 1, on "Reports of Officers and Standing Committees."
     G. Dan Delprat, Chairman, San Francisco; Louis J. Regan, Los Angeles; H. F. Freidell, Santa Barbara.
   - (*b*) Report of Reference Committee Number 2, on "Report of the Council, and Reports of Secretary-Treasurer, and Executive Secretary."
     E. T. Remmen, Chairman, Glendale; Brodie Stephens, San Francisco; E. W. Page, Alameda.
   - (*c*) Report of Reference Committee Number 3, on "Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business."
     Dwight L. Wilbur, Chairman, San Francisco; C. J. Berne, Los Angeles; A. E. Moore, San Diego.

† † †

8. Unfinished Business.
9. New Business.
10. Presentation of Officers:
    President
    President-Elect
    Speaker
    Vice-Speaker
11. Presentation of Certificate to Retiring President Lowell S. Goin.
12. Approval of Minutes. (Committee to edit.)
13. Adjournment.

E. Vincent Askey *Speaker,*
George H. Kress, *Secretary.*

** *Procedure of nomination of District Councilors is outlined in paragraph 3 of Article VII, Section 1, of C.M.A. constitution, adopted on May 8, 1940:*

The nine district Councilors shall be elected as follows:

Prior to the time set for election of district Councilors, the delegates of each Councilor district for which a councilorship is about to become vacant, shall submit in writing to the Secretary-Treasurer the names of one or more nominees to fill the said vacancy.

The Secretary-Treasurer shall transmit the names of such nominee or nominees so submitted to him to the House of Delegates on or before the time set for the election.

A vote shall be taken by the House of Delegates upon the nominee or nominees so submitted and, in the event that only one nominee has been submitted, the House of Delegates may, by a majority vote, either elect or refuse to elect said nominee.

If the House of Delegates shall reject the sole nominee of the delegates from the councilorship district, concerned, then said delegates must immediately thereafter submit an additional nominee or nominees and the House shall proceed to vote thereon; if there is but one nominee, the House may elect or reject.

If, after such time as the Speaker may allow, delegates within such councilor district fail to submit an additional nominee or nominees, the House of Delegates may then proceed to make nominations from the floor of the House and a vote shall then be taken by the House of Delegates to determine who shall be elected to the vacant councilorship.

All nominees for district councilorships must be members in good standing, residing within the district in which the vacancy exists.

Proposed Amendment to C.M.A. Constitution

Re: Ex-officio Members of Council

Be It Resolved, That the first paragraph of Section 1, Article VII, of the Constitution of the California Medical Association be amended to read:

"The Council shall consist of the Councilors, and ex-officio: The President, the President-elect, the Speaker and Vice-Speaker of the House of Delegates, each with all the rights of a Councilor."

and, be it

Resolved, That the first paragraph of Section 4, Article X of the Constitution of the California Medical Association be amended to read:

"The President, President-elect, the Speaker and Vice-Speaker of the House of Delegates shall be ex-officio members of the Council with all the rights of Councilors."

† Committees will be announced in programs to appear later.

Each of the aforesaid committees shall consist of three members, the chairman of each to be designated by the Speaker.

The Speaker, the House concurring, shall refer said reports, resolutions, and business to the respective Reference Committees, but may allocate among them any of said reports, resolutions or portions thereof, and other business, to avoid duplication and to expedite the business of the House of Delegates.

The Reference Committee shall present written reports dealing with and making recommendations on all matters submitted to them. The report of each committee shall be read by its chairmán first as a whole, and the House of Delegates shall then act and vote upon the report as a whole or section by section, as it may deem best.

† Reports of officers, standing and special committees appear in full text in the "Pre-Convention Bulletin."

SCIENTIFIC ASSEMBLY–GENERAL AND SECTION MEETINGS

II

GENERAL MEETINGS

For index of speakers, see page 199

All General Meetings will be held in the Ball Room (at the South End of the North-South Galeria)

Section Meetings will be held in Conference Rooms (near Grand Avenue entrance of East-West Galeria; use stairway to mezzanine floor).

Request is made for prompt attendance, to permit afternoon Section Programs to begin as per schedule, at 1:30 p.m.

First General Meeting
Tuesday Morning, May 7, 1946, at 9:00 a.m.

Presiding

Lowell S. Goin, *Past President*
Philip K. Gilman *President*

(1)

Invocation—Reverend Wilbur Fix.

(2)

Address of Welcome—Louis J. Regan, M.D., President of the Los Angeles County Medical Association.

(3)

Greetings from the Woman's Auxiliary—Mrs. Ralph Eusden, President of the Woman's Auxiliary to the California Medical Association.

(4)

Report: State Department of Public Health—Wilton L. Halverson, M.D., San Francisco.

(5)

Report: State Board of Medical Examiners—Frank W. Otto, M.D., Los Angeles.

(6)

Medicine and the Atomic Power—Robert S. Stone, M.D., University of California, San Francisco.

(7)

Address of President—Philip K. Gilman, M.D., San Francisco, President of the California Medical Association.

(8)

Problems in the Endocrine Aspects of Convalescence—Allan T. Kenyon, M.D., University of Chicago, Chicago, Illinois.

The endocrine aspects of convalescence will be discussed especially with reference to rates of nitrogen retention. The possibilities and the limitations of using hormones with anabolic influences to induce and accelerate the metabolic process will be outlined.

(9)

CLINICAL-PATHOLOGICAL CONFERENCE

Presentation of Three Case Histories—Under joint chairmanship of William P. Kroger, M.D., of Los Angeles, and S. P. Luciá, M.D., of San Francisco.

* * *

Case No. 1: Pathologist James Rinehart, M.D., University of California Hospital, San Francisco; with clinician, Allan T. Kenyon, M.D., University of Chicago Medical School, Chicago.

* * *

Case No. 2: Pathologist Hugh Edmondson, M.D., Los Angeles County General Hospital, Los Angeles; with clinician, Verne Mason, M.D., 523 West Sixth Street, Los Angeles.

* * *

Case No. 3: Pathologist Gilbert Curtis, M.D., 1200 North State Street, Los Angeles; with clinician, J. Homer Woolsey, M.D., Woodland Clinic, Woodland.

(10)

Tumors of Infancy and Childhood—George T. Pack, M.D., 139 East 36th Street, New York City.

The incidence and classification of tumors, benign and malignant occurring in infancy and childhood are presented. Special problems in treatment are given and illustrative cases will be shown.

(11)

Malpractice—Let's Face It—Louis J. Regan, M.D., LL.B., 6777 Hollywood Boulevard, Los Angeles.

No more serious problem faces the profession today than that of malpractice. After World War I there was a tremendous increase in the incidence of malpractice claims. Further increase must now be anticipated. The situation can be improved by concerted aggressive action by the whole medical group.

(12)

What Physicians Should Know Regarding Medical-Legal Phases Concerning Adoption of Newborn and Other Children—Donald G. Tollefson, M.D., 511 South Bonnie Brea Street, Los Angeles.

Over 5,000 adoption petitions on file in California and an equal number of prospective parents who have petitions on file give some idea of the scope of this problem. Adoptions are best handled by approved agencies. A committee of medical, legal and welfare workers is studying this problem; the results will be presented.

Second General Meeting
Thursday Afternoon, May 9, 1946, at 1:30 p.m.

Presiding

Philip K. Gilman, *President*
Salvatore P. Lucia, *Chairman, Section on Medicine*
William P. Kroger, *Chairman, Section on Surgery*

(13)

Human Reactions During Experimental Aircraft Crash Investigations—Comdr. Howard R. Bierman (MC), U.S.N.R., Naval Medical Research Institute, National Naval Medical Center, Bethesda, Maryland.

A motion picture will illustrate the talk (film, about 15 minutes). Also some lantern slides to illustrate tracings of the various physiological phenomena which have been observed. Perhaps, also, two or three interesting gadgets which have been developed to record the peripheral pulse, respirations and the blood pressure, all of which should be interesting to general medicine. The film will contain many high speed motion picture sequences which were taken at 3,000 frames per second.

III

OFFICIAL CALL

To the Officers and Members of the California Medical Association:

The seventy-fifth annual session of the California Medical Association will be held in Los Angeles, California, from Tuesday, May the seventh, to Friday noon, May the tenth, Nineteen hundred and forty-six.

The Horse of Delegates will convene on Tuesday, May the seventh.

The Scientific Assembly of the Association will open with the General Meeting held on Tuesday, May the seventh, at 9 A.M.

The various sections of the Scientific Assembly will begin meetings on Tuesday, May the seventh, at 1:30 P.M. and subsequently at 9:00 A.M. and 1:30 P.M., according to their respective programs.

PHILIP K. GILMAN,
President.

E. VINCENT ASKEY,
Speaker, House of Delegates.

Attest:

GEORGE H. KRESS,
Secretary.
March the twentieth,
San Francisco, California.

IV

SECTION MEETINGS

For index of speakers, see page 199

SCIENTIFIC SECTION PROGRAMS

(Numbers in parenthesis after each section indicate sequence reference numbers of papers read in each section.)

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REGISTRATION INFORMATION

1. Registration and Information. Registration and information desks are located in the Renaissance Room (large room on left, as one enters from Fifth Street—north end of galeria). All members, guests and visitors are requested to register immediately on arrival. Registration secretaries will be on duty from 8:30 a.m. to 5 p.m.

2. Meeting Rooms of General Meetings and Scientific Sections. The Ballroom at the south end of main galeria (immediately adjacent to ramp entrance) will be used for general meetings and for Sections of Medicine and Surgery. Other sections (unless otherwise stated) will meet in Conference Rooms on the mezzanine floor. (Conference rooms are entered from the east-west galeria, close to the Grand Ave. entrance).

3. Annual Session Program. Copies of complete session proceedings, showing times and places of all meetings, are available at the registration desk.

4. House of Delegates. Meetings will be held in Music Room, on east-west galeria, near the main elevators.

5. Woman's Auxiliary. Meetings in Rooms 3333 and 3334, on the third floor.

6. Commercial Exhibits. In Renaissance Room, near 5th Street entrance, and in foyer of Ballroom, near south auto ramp.

No Scientific Exhibits or Medical Films this year owing to existing conditions.

7. Whom to Consult for Special Information. The following activities are under the supervision of Dr. Kress, Association Secretary and Chairman of the Committee on Scientific Program:

(a) General Meetings Programs
(b) Section Meeting Programs
(c) Equipment of Meeting Rooms

Since Dr. Kress is also secretary of the Council and House of Delegates, he will be represented by his secretaries. At the information desk in the ball-room by Mrs. Straus, and on the mezzanine conference floor by Miss Beauchamp.

Registration Desks and Commercial Exhibits are under the supervision of the Executive Secretary, Mr. Hunton. Mr. Hunton's desk is at the registration table.

8. Pre-Convention Bulletin. Annual reports of officers, councilors and committees appear in the April issue of CALIFORNIA AND WESTERN MEDICINE. Additional copies of these reports will be made available to delegates and alternates either at the registration desk or at the first meeting of the House of Delegates.

9. Tickets for "Dinner to the President." For information, see under Entertainment. Tickets will be on sale at Registration Desk. Special reservations available for parties of eight or more. "Tables Reserved" must not be occupied by others. Please observe this hotel and convention rule.

10. Badges and Programs. Badges and programs will be issued at the registration desk in the Renaissance Room, near 5th Street entrance.

11. Guests and Visitors. All guests and visitors are requested to register. All general meetings and scientific meetings are open to visitors and guests so registered. There is no charge for registration.

12. Rules Regarding Papers and Discussions at Annual Sessions. Section Officers, Essayists, and Members taking part in discussions are requested to read the rules adopted by the C.M.A. Council and the C.M.A. Committee on Scientific Work, relating to papers and discussions. These will appear in the pocket programs, to be distributed at the Registration Desk. Proper and impersonal observance of these rules by all concerned will make for more successful meetings.

Essayists must hand their papers to Section Secretaries, who will forward same to C.M.A. central office.

13. Business Meetings of Scientific Sections. For convenience in make-up of Section programs, the business meeting of each Section is scheduled to follow the second paper on a Section program (at a time when there is a good average attendance). However, each Section can change the time for its organization meeting and election of officers for the succeeding year, in accordance with the wishes of the Section members. (So also, as regards sequence of addresses.)

14. Bulletin Boards. Consult bulletin boards in the galeria for announcements of special events.

I

GENERAL MEDICINE SECTION

Meetings in Ball Room—At the south end of the North-South Galeria

(Entrance by way of Technical Exhibit Foyer)

SALVATORE P. LUCIA, M.D., *Chairman*
2898 Broadway, San Francisco

FRANCIS L. CHAMBERLAIN, M.D., *Secretary*
490 Post Street, San Francisco

HOWARD O. DENNIS, M.D., *Assistant Secretary*
9730 Wilshire Boulevard, Beverly Hills

First Meeting

Wednesday, May 8, 9:00 a.m.

Paper No. 14:

Chairman's Address—The Trend of Medicine and Its Relationship to the Prevention of Disease—Salvatore P. Lucia, M.D., University of California Hospital, San Francisco.

The practice of medicine transcends the science of diagnosis and the art of therapeutics. It must place renewed emphasis on the subject of the prevention of disease, and this compels a more careful study of those natural phenomena incidental to the art of living, and upon which soundness of mind and body, and the fulfillment of a useful life depends.

Paper No. 15:

Management of Cardiospasm—Rudolf Schindler, M.D., 1052 West Sixth Street, Los Angeles.

Cardiospasm is a curable disease. Method of choice, because leading to permanent results, is the non-surgical forceful dilatation of the cardia. An umbrella-like metal dilator is recommended. The special management and the results obtained are discussed.

Discussion by Lester M. Morrison, M.D., Los Angeles.

PANEL DISCUSSION ON ENDOCRINE THERAPY

Moderator: Allan T. Kenyon, M.D., University of Chicago Medical School, Chicago.

Paper No. 16:

Clinical Use of Estrogens—S. Charles Freed, M.D., Mt. Zion Hospital, San Francisco.

A discussion of the relative activities of the numerous oral estrogens now available will be made. The principles controlling the efficiency of injectable estrogens will also be discussed as well as the experimental results with newer dosage forms of estrogens such as aqueous suspensions.

Paper No. 17:

Improved Forms of Insulin—Cyril M. MacBryde, M.D., 921 Westwood Boulevard, Los Angeles.

Modified protamine zinc insulin offers many advantages over market protamine zinc insulin in the regulation of diabetes. In 110 cases studied during four years, good regulation was established in 98 patients (90 per cent) with a single injection of MPZ insulin daily. Severe as well as mild cases were well-controlled, 64 per cent of the well-regulated cases being severe enough to require over 40 units daily, some needing as much as 120 units (average 73 units). Such good control excels that obtainable with any other form of insulin. Mixing insulins is to be deprecated.

Paper No. 18:

Thiouracil in the Treatment of Thyroid Disease—Mayo H. Soley, M.D., University of California Hospital, San Francisco.

Thiouracil depresses the production of thyroid hormone and therefore has its greatest value in the preparation of patients with severe Graves' disease for subtotal thyroidectomy. The administration of iodine for one to two weeks preoperatively decreases the vascularity of the thyroid and makes thyroidectomy technically easier. Necessity for frequent blood counts and the probability of recurrence of hyperthyroidism when thiouracil is discontinued limits the use of thiouracil in the non-surgical treatment of hyperthyroidism. For unknown reasons, thiouracil is useful in subacute thyroiditis. Toxic effects are nausea and perhaps vomiting, rashes, fever, adenopathy, leukopenia and agranulocytosis.

Paper No. 19:

Use and Abuse of Thyroid—E. Kost Shelton, M.D., 921 Westwood Boulevard, Los Angeles.

Too much dogmatism is employed in the interpretation of the basal metabolic rate and of certain clinical symptoms as indices of thyroid requirement. True hypothyroid states are frequently produced in normal individuals by the injudicious use of desiccated thyroid for pseudo hypothyroid states. Because of this phenomenon the therapeutic test is often erroneously interpreted. More careful laboratory data and better clinical judgment are necessary to arrive at a diagnosis in unconventional problems.

Paper No. 20:

Clinical Indications for and Modes of Administration of Testosterone—Hans Lisser, M.D., 384 Post Street, San Francisco.

The male hormone, testosterone, is a pure chemical, synthetically produced. It is *not an extract* of either animal or human testes. Only four pharmaceutical firms in the United States have the right to produce this material. When given in proper dosage, for those conditions for which it is indicated, it can be counted upon to produce consistently satisfactory improvement. It is every bit as potent and reliable as thyroid substance or insulin. In the form of testosterone propionate in oil, it may be injected intramuscularly and is available in 5 mg., 10 mg., and 25 mg. ampoules. For mild doses, or in infants, it may be massaged into the skin being incorporated in a bland ointment. In the form of crystalline pellets testosterone may be implanted under the skin in doses ranging from 150 to 1,000 mgms. at one time; one such tablet will continue to be effective for many months depending on the dosage used. In the form of methyl testosterone, available in 10 mgm. tablets, the male hormone is potent when swallowed; about three times the dose is necessary perorally to produce the same effect as when injected. The most economical manner, and also efficient way of administering testosterone, is in the form of methyl testosterone linguets, available in 5 mg. hard compressed tablets, absorbed directly from under the tongue or the buccal cavity. This route is two to three times as efficient as when the tablets are swallowed.

Paper No. 21:

Problems in Growth—Allan T. Kenyon, M.D., University of Chicago Medical School, Chicago.

Certain aspects of normal growth which must be taken into account in the analysis of growth defects and of remedial agents will be considered. The properties of hormonal agents in accelerating growth will be discussed.

Allan T. Kenyon, M.D., and Panel members will answer questions on Endocrine Therapy. Questions must be submitted in writing, and sent up to the panel table.

✣

Second Meeting

Thursday, May 9, 9:00 a.m.

Joint Meetings With Sections on General Surgery and Radiology

PANEL DISCUSSION ON DIAGNOSIS AND TREATMENT OF PULMONARY SUPPURATION

Paper No. 22:

Co-Moderators: Reginald Smart, M.D., 1136 West Sixth Street, Los Angeles, and Emile Holman, M.D., Stanford University Hospital, San Francisco.

Pulmonary Suppuration: panel discussion; presentation of illustrative cases with clinical history and roentgen films, discussed from the standpoint of diagnosis, and medical and surgical treatment. The participants will endeavor to answer questions from the floor (handed up in writing).

Paper No. 23:

Robert Newell, M.D., Stanford University Hospital, San Francisco.

Paper No. 24:

Sidney Shipman, M.D., 490 Post Street, San Francisco.

Paper No. 25:

Stephen Dolley, M.D., 1930 Wilshire Boulevard, Los Angeles.

Paper No. 26:

Paul C. Samson, M.D., 805 Highland Avenue, Piedmont.

This is to be a joint panel with members of the Sections on Medicine, Surgery, and Radiology participating. It is to be a discussion of a group of representative cases illustrating the various common types of pulmonary suppuration, with a consideration of diagnosis and treatment—both medical and surgical.

If time permits, questions submitted in writing, and sent up to the moderators, may be answered.

* * *

Recess

Second Half of Program

PANEL DISCUSSION ON PHLEBOTHROMBOSIS AND THROMBOPHLEBITIS, AND ITS MEDICAL AND SURGICAL MANAGEMENT

Moderator: C. J. Berne, M.D., 2023 Redcliff Street, Los Angeles, who will open the discussion.

Paper No. 27:

Phlebothrombosis and Thrombophlebitis—Introductory Comment—C. J. Berne, M.D., 1136 West Sixth Street, Los Angeles.

In past years there has been presented at the Annual Meetings a number of excellent papers on Venous Thrombosis and Embolism, Heparin and Dicumarol. The present much greater use of the anticoagulant drugs has been paralleled by advances in surgical procedures for control of venous thrombosis. The panel to be presented is intended to review and correlate all these phases. A summary of the incidence, clinical types, morbidity, mortality, and pathogenesis of venous thrombosis will be given by the moderator of the panel as a prelude to the presentations by the collaborators.

Paper No. 28:

Venography, Advantages and Limitations—Earl R. Miller, M.D., University of California Hospital, San Francisco.

The technique of venography and the meaning of some of its results will be discussed.

Paper No. 29:

The Blood Clotting Mechanism and Tests for Its Efficiency—Roy W. Hammack, M.D., 657 South Westlake Avenue, Los Angeles.

The Factors Involved in Coagulation. The Source and properties of Prothrombin. The Formation of Thrombin and the Nature of its Action. The Purpose of Coagulation. Practical Laboratory Methods for Estimation of Prothrombin and Coagulation time.

Paper No. 30:

The Use of Anticoagulants Heparin and Dicumarol—Salvatore P. Lucia, M.D., University of California Hospital, San Francisco.

A discussion of the mechanism of action of anticoagulants in general, and heparin and dicumarol in particular, with details of the technique of administration.

Paper No. 31:

The Physical Management of Phlebothrombosis and Thrombophlebitis—Leon Goldman, M. D., and Stanley G. Johnson, M.D., University of California Hospital, San Francisco.

A report of phlebothrombosis and pulmonary embolism in postoperative and medical patients seen at the San Francisco Hospital during the past three years. The indications and techniques of femoral and iliac vein ligation will be discussed.

✣

Third Meeting

Thursday, May 9, 1:30 p.m.

General Session, in Joint Meeting with Sections on General Surgery and Medicine

CLINICAL-PATHOLOGICAL CONFERENCE

Three Case Histories—Under joint chairmanship of William Kroger, M.D., of Los Angeles, and S. P. Lucia, M.D., of San Francisco.

Paper No. 32:

Case No. 1: Pathologist James Rinehart, M.D., University of California Hospital, San Francisco; with clinician Allan T. Kenyon, M.D., University of Chicago Medical School, Chicago.

Paper No. 33:

Case No. 2: Pathologist Hugh Edmondson, M.D., Los Angeles County General Hospital, Los Angeles; with clinician Verne Mason, M.D., 523 West Sixth Street, Los Angeles.

Paper No. 34:

Case No. 3: Pathologist Gilbert Curtis, M.D., 1200 North State Street, Los Angeles; with clinician J. Homer Woolsey, M.D., Woodland Clinic, Woodland.

✣

Fourth Meeting

Friday, May 10, 9:00 a.m.

Paper No. 35:

Physiological Basis for the Treatment of Intractable Asthma—Hyman Miller, M.D., 123 North San Vicente Boulevard, Beverly Hills.

Many remedies, although diametrically opposed in pharmacologic effects, have been reported effective in the relief of intractable asthma. The answer to this paradox lies in a proper appreciation of the pathological physiology involved. On this basis the treatment herein described has been developed and has been in successful use at the Los Angeles General Hospital.

Discussion by Albert Rowe, M.D., Oakland.

Paper No. 36:

Chrysotherapy in Rheumatoid Arthritis—Hans Waine, M.D., Francis Baker, M.D., and Stacy R. Mettier, M.D., University of California Hospital, San Francisco.

One hundred and twenty patients with active peripheral rheumatoid arthritis were followed for an average time of over three years. About half of these received intensive conservative treatment while the others had chrysotherapy in addition. The results show that twice as many patients in the gold treated series lost all evidence of active disease as in the control series. The indications for gold in arthritis, its mode of administration and its limitations are discussed.

Discussion by Pierre J. Walker, M.D., Los Angeles.

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Business Recess

Business Meeting and Election of Officers

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Paper No. 37:

The Natural History of Streptococcus Disease—Lowell Rantz, M.D., Stanford University Hospital, San Francisco.

The natural history of hemolytic streptococcus sore throat in young adults has been studied. The symptoms, signs and course of the acute disease will be described as will the suppurative and non-suppurative complications that so frequently followed the initial illness.

Discussion by John Brown, M.D., San Francisco.

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Recess

10:30 a.m.

Symposium on Clinical Use of Antibiotics

Paper No. 38:

Penicillin, Sulfonamide, and Serum Therapy of Purulent Meningitis—Henry Brainerd, M.D., and Elizabeth Bradley, M.D., San Francisco Hospital, San Francisco.

This report analyzes the experience obtained during the years 1943 to 1946 at the Isolation Division, San Francisco Hospital, in the treatment of acute bacterial meningitis of all types. The relative values of sulfadiazine, sulfamerazine, penicillin, and various antibacterial sera are compared, and indications for each type of therapy are promulgated on the basis of certain prognostic data.

Paper No. 39:

Treatment of Pneumococcus Pneumonia: Comparison of Sulfonamides, Parenteral Penicillin, and Oral Penicillin—A Study of 3,000 Cases—Morris F. Collen, M.D., Permanente Foundation Hospital, Oakland.

This study indicates that penicillin is the drug of choice in routine treatment of pneumococcic pneumonia because of its effectiveness and low toxicity. In mild and moderately severe pneumonia oral penicillin is simplest to administer and clinically is as effective as parenteral penicillin. In severe pneumonia combined penicillin and sulfadiazine therapy is indicated.

Paper No. 40:

Status of Penicillin in the Treatment of Syphilis—Charles W. Barnett, M.D., Stanford University Hospital, San Francisco.

The results of penicillin therapy in early syphilis under various dosage schedules are discussed. The futility of penicillin as a desperation measure in Wasserman fast latent syphilis is pointed out and the indications for its use in other types of late syphilis are outlined.

Paper No. 41:

Antibiotics in the Treatment of Streptococcus Disease—Lowell Rantz, M.D., Stanford University Hospital, San Francisco.

Penicillin was used alone and in combination with sulfonamides in the treatment of a large number of cases of hemolytic streptococcus sore throat with and without rash. The results of this study will be summarized.

Round Table discussion by members of the panel answering questions submitted in writing.

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Fifth Meeting

Friday, May 10, 1:30 p.m.

Joint Meeting of Section on Medicine with California Heart Association

Dr. Louis Martin and Dr. Salvatore P. Lucia, presiding.

Paper No. 42:

The Present Status of Surgery in Congenital Heart Disease—John C. Jones, M.D., 1136 West Sixth Street, Los Angeles.

A discussion of the status of the surgical treatment of patent ductus arteriosis, Tetralogy of Fallot, and coarctation of the aorta; indications and contraindications for operative correction and surgical complications.

Discussion by H. Brodie Stephens, M.D., San Francisco, and Emile Holman, M.D., San Francisco.

Paper No. 43:

Quinidine—Its Uses in Heart Disease—S. A. Weisman, M.D., 1136 West Sixth Street, Los Angeles.

This report consists of a series of animal experiments and clinical studies on over 500 patients. A method of treatment is presented which not only lessens, but often prevents the dangers and toxic symptoms so frequently attributed to the use of the drug.

Discussion by George Houck, M.D., Palo Alto.

Paper No. 44:

The Detection of Cardiac Abnormalities with Miniature (4 x 5) Film—Joseph Jellen, M.D., 923 South Sycamore Avenue, Los Angeles, and William Paul Thompson, M.D., 1930 Wilshire Boulevard, Los Angeles.

The incidence of cardiac abnormalities is shown in a large chest survey group using miniature (4 x 5) films. Comparative studies of heart size are presented using 4 x 5 films, 14 x 17 films, and orthodiagrams. Criteria are suggested for the selection of abnormal hearts with miniature films.

Discussion by Robert Newell, M.D. San Francisco.

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Recess

Symposium on Rheumatic Fever in Adults

Paper No. 45:

Some Clinical Aspects of Rheumatic Fever in Adults on the Pacific Coast—Maurice Eliaser, M.D., 490 Post Street, San Francisco.

Rheumatic Fever among adults on the Pacific Coast presents diagnostic problems associated with the apparently mild nature of the articular phase of the acute disease. The premonitory diseases, cardiac lesions, and laboratory data in a group of critically observed patients are described.

Paper No. 46:

Sudden Death in Rheumatic Fever—George C. Griffith, M.D., 117 East Colorado Street, Pasadena.

Thirteen deaths occurred in a series of over 10,000 rheumatic fever patients of military age. Three of these deaths were sudden, dramatic and unexpected. Two of the three patients were considered to have reached the quiescent phase of the disease.

All three patients died of acute myocardial infarction. The histopathologic studies revealed an acute collagenous effusion of sufficient degree to occlude vital coronary arteries. These arterial changes were adjudged examples of an acute anaphyllactic angilitis.

Paper No. 47:

The Electrocardiogram in the Diagnosis and Management of Rheumatic Fever—Maurice Sokolow, M.D., University of California Hospital, San Francisco.

The presence of carditis is a most important criterion in the evaluation of an illness suspected to be rheumatic fever. In adults, carditis is mostly commonly demonstrated by the appearance of significant electrocardiographic abnormalities. Data illustrating these abnormalities and their significance will be presented.

Paper No. 48:

Differential Diagnosis of Adult Rheumatic Fever and Rheumatoid Arthritis—Ephraim P. Engleman, Major, M.C., San Francisco.

Acute rheumatoid arthritis and adult rheumatic fever have been compared, and differential diagnostic features are presented. Army experience has supported a previously recorded observation that rheumatoid arthritis is more frequently misdiagnosed as rheumatic fever than the reverse. Emphasis is therefore placed on rheumatoid manifestations which superficially simulate those of rheumatic fever. It is concluded that in most cases early and accurate differentiation between these two diseases can be made.

Election of Officers of California Heart Association.

II

GENERAL SURGERY SECTION

Meetings in Ball Room—At the south end of the North-South Galeria

(Entrance by way of Technical Exhibit foyer)

William P. Kroger, M.D., *Chairman*
1930 Wilshire Boulevard, Los Angeles

Eugene J. Joergenson, M.D., *Secretary*
632 North Brand Boulevard, Glendale

A. Morse Bowles, M.D., *Assistant Secretary*
541 Fourth Street, Santa Rosa

First Meeting

Tuesday, May 7, 1:30 p.m.

Paper No. 49:

Chairman's Address—Hypoparathyroidism—William P. Kroger, M.D., 1930 Wilshire Boulevard, Los Angeles.

The discussion of the subject is confined to post thyroidectomy hypoparathyroidism; acute and chronic or latent hypoparathyroidism is considered. The incidence, etiology, symptoms, and treatment will be discussed. Special emphasis will be placed upon the specific action of dihydrotachysterol.

Paper No. 50:

Acute Pancreatitis—J. Howard Payne, M.D., 1327 Norfolk Street, Los Angeles.

A study of acute pancreatitis, based on admissions to the Los Angeles County General Hospital, with special emphasis on symptoms, laboratory findings, and prognosis.

Discussion by John Paxton, M.D., Glendale.

Paper No. 51:

Management of Malignant Melanoma—George T. Pack, M.D., and Samuel Perzik, M.D., Memorial Hospital for Cancer and Allied Diseases, New York.

End result in 950 cases will be given. The treatment of this most malignant and fatal of all superficial cancers is discussed. The principle of excision and dissection in continuity for primary metastatic melanoma is presented. Special problems dealing with melanomas of various locations are considered.

Discussion by George T. Pack, M.D., New York City.

Recess

Second Half of Program

Joint Meetings with Section on Industrial Medicine and Surgery

Panel Discussion on Surgery of the Hand

Chairman of Panel: Sterling Bunnell, M.D.

Paper No. 52:

The Mechanics of Hand and Fingers, and Disturbances from Injuries—Jacob Janzen, M.D., 312 North Boyle Avenue, Los Angeles.

A brief review of the salient features of the anatomy of the hand, with attention to its normal mechanism and with special emphasis on the finger mechanism and on the influence of muscles in fractures and other injuries.

Paper No. 53:

Primary Treatment of Open Wounds of the Hand—John E. Kirkpatrick, M.D., 516 Sutter Street, San Francisco.

Wounds of the hand constitute a surgical emergency unsuitable for office or emergency room care in most instances, consequently hospital and surgical priorities are a necessity. Adequate anesthesia, a bloodless field, gentle skin cleansing with detergents, meticulous excision of only nonviable tissue, anatomical and physiological repair, pressure dressings, and splinting in the position of maximum function are essential for restoration of function. The "golden hours" for primary repair may be extended with penicillin and oral sulfadiazene in selected cases where complicated injuries require the service of a surgeon at a distant hospital.

Paper No. 54:

Infection of the Hand with Evolution of Chemotherapy—Joseph H. Boyes, M.D., 1401 South Hope Street, Los Angeles.

Chemotherapy has proven of value in the treatment of infections but their use has not supplanted the surgical drainage of certain types of infections of the hand. Particularly in tendon sheath infections where swelling beneath the unyielding annular ligaments and pulleys causes ischemic necrosis of the tendons and nerves, it is still important to properly diagnose and surgically treat the infected hand. Slides will be used to illustrate the areas most vulnerable to this type of damage and the indicated treatment discussed.

Paper No. 55:
Amputation of the Hand and Fingers—Vernon P. Thompson, M.D., 860 South Hudson, Los Angeles.

Paper No. 56:
Treatment and Prevention of Stiff Joints of the Hand and Fingers, Including Trophic Disorders—Lt. Col. Donald Pratt (MC), Dibble General Hospital, Menlo Park.

The various methods of mobilizing stiffened finger joints by splints will be demonstrated. The details in the operative procedures of arthroplasty and capsulotomy will be outlined. Discussion of a group of contractures resulting from post-traumatic vascular and trophic changes.

General discussion.

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Second Meeting

Wednesday, May 8, 1:30 p.m.

Joint Meeting with Section on Anesthesiology

Paper No. 57:
Physiology of Traumatic Reflexes and Respiration During Surgical Anesthesia: Quantitative and Pneumographic Studies Under Pentothal and Local Nerve Block—James C. McCann, M.D., Worcester, Massachusetts.

This study is based on the hypothesis that anesthesia under sodium pentothal establishes in the human the basic experimental condition of "functional decerebration." Reflex arcs of the infracerebral nerve centers are preserved intact during surgical planes of anesthesia. This permits accurate physiological observations of the reflex stimulation of respiration by surgical pain stimuli. Studies of the rate of utilization of pentothal in general surgery revealed that the major factor determining the quantitative use of pentothal was the intensity of the reflex stimulation of the respiratory center by surgical trauma. The pain impulses have been interrupted strategically with direct procaine nerve block, and the rate of utilization of pentothal sharply reduced. Clinical observations were made of specific reflex respiratory responses to trauma from segmental areas of the body (cervical, thoracic, lumbar, sacral) with pneumograms. Demonstration of the segmental specificity of different types of reflex respiratory response was thus established. Counterproof of their specificity and character was accomplished by blocking out the specific areas with procaine nerve block and repeating the pneumograms. Thus in the human an experimental study of the physiology of surgical anesthesia has been made. The results appear to be of significance whatever the anesthetic agent used.

Recess

Paper No. 58:
The Effect of Sulfonamide Drugs on Postoperative Morbidity and Mortality in Colon Surgery—H. Glenn Bell, M.D., University of California Hospital, San Francisco.

An attempt has been made to correlate the morbidity, mortality, and end results in large bowel surgery, with and without the use of chemotherapy. It is the feeling that the present day chemotherapy is quite an adjunct to large bowel surgery, but the fact must be stressed that it will never take the place of adequate surgery.

Discussion by Robert Scarborough, M.D., San Francisco.

Paper No. 59:
Two-Team Abdominoperineal Resection—Malcolm R. Hill, M.D., 1216 Wilshire Boulevard, Los Angeles, and Robert L. Belt, M.D., 229 North Central Avenue, Glendale.

The use of a double operative team in abdominoperineal resection of the rectum for carcinoma of the anus, rectum, and rectosigmoid is reviewed and illustrated with motion pictures in color.

Discussion by John R. Paxton, M.D., Glendale.

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Business Recess

Business Meeting and Election of Officers

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Joint Meeting with Section on Radiology

PANEL DISCUSSION ON CARCINOMA OF THE STOMACH

Chairman of Panel: Thomas F. Mullen, M.D.

Paper No. 60:
A general discussion of the factors responsible for the delay in establishing the diagnosis of, and thus delaying the surgical treatment of carcinoma of the stomach.

Paper No. 61:
What Can the Internist Do to Get More Early Cases to the Surgeon?—Clayton D. Mote, 384 Post Street, San Francisco.

It should not be necessary to emphasize that the presence of carcinoma of the stomach must be recognized early if the results in the treatment of the disease are to be improved. There must be an increasing awareness on the part of doctor and patient alike if more cases are to have the benefit of surgery early in the course of the disease.

Paper No. 62:
The Place of Gastroscopy in the Early Diagnosis of Cancer of the Stomach—Rudolf Schindler, M.D., 1052 West Sixth Street, Los Angeles.

The exactitude with which even finest changes of the mucosa may be recognized at gastroscopy is usually under-estimated. Early differentiation between benign and malignant ulcer often becomes possible. The observation of cases with precancerous conditions offers the possibility to discover beginning malignancies. (With colored slides.)

Paper No. 63:
Problems in the X-ray Diagnosis of Early Cancer of the Stomach—Kenneth S. Davis, M.D., St. Vincent's Hospital, Los Angeles.

The importance of diagnosis of early cancer of the stomach is obvious when one considers that 75 per cent of gastric carcinomas are found to be inoperable. Cancers of the stomach may be grouped into (1) those arising on health gastric mucosa, and (2) those arising on previously diseased mucosa.

In group 1 the roentgen findings are the filling defect, corresponding palpable mass, lack of normal flexibiilty of the stomach wall and absence of peristalsis in the region of involvement.

In group 2—benign gastritis, polyps and gastric ulcer must be differentiated from early cancer. It is in this group that most of our problems in differential diagnosis are encountered.

Paper No. 64:

What Are the Recent Advances Made in the Surgical Treatment of Cancer of the Upper End of the Stomach?—Gunther W. Nagel, M.D., 2000 Van Ness Avenue, San Francisco.

The transthoracic approach is a satisfactory method for resection of carcinomas of the cardiac end of the stomach.

Contributing to the success of these procedures are the recent developments in intratracheal anesthesia and the prevention of infection by the use of penicillin and the sulfa drugs.

Paper No. 65:

End Results in the Treatment of Gastric Cancer—George T. Pack, M.D., 139 East 36th Street, New York City.

Figures covering the resectability rate, the operative mortality and the period of definitive cures are presented with a review of all the prognostic factors which influence these end results. Methods of improving these percentages are explained. Palliative measures in the management of gastric cancer are evaluated.

General Discussion. Questions in writing, to be passed up to the Moderator, who will inspect the same and distribute to members of the panel.

✣

Third Meeting

Thursday, May 9, 9:00 a.m.

Joint Meeting with Sections on General Medicine and Radiology

PANEL DISCUSSION ON PULMONARY SUPPURATION

Co-Moderators: Reginald Smart, M.D., 1136 West Sixth Street, Los Angeles, and Emile Holman, M.D., Stanford University Hospital, San Francisco.

(See Papers 22-26)

Robert Newell, M.D., Stanford University Hospital, San Francisco.

Sidney Shipman, M.D., 490 Post Street, San Francisco.

Stephen Dolley, M.D., 1930 Wilshire Boulevard, Los Angeles.

Paul C. Samson, M.D., 805 Highland Avenue, Piedmont.

This is to be a joint panel in which members of the Sections on Surgery, Medicine, and Radiology will participate. It is to be a discussion of a group of representative cases illustrating the various common types of pulmonary suppuration, with a consideration of diagnosis and treatment—both medical and surgical.

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Second Half of Program

PANEL DISCUSSION ON PHLEBOTHROMBOSIS AND THROMBOPHLEBITIS AND ITS MEDICAL AND SURGICAL MANAGEMENT

Moderator: C. J. Berne, M.D., Los Angeles. He will open the discussion.

Paper No. 27:

Phlebothrombosis and Thrombophlebitis—Introductory Comment—C. J. Berne, M.D., 1136 West Sixth Street, Los Angeles.

In past years there has been presented at the Annual Meetings a number of excellent papers on Venous Thrombosis and Embolism, Heparin and Dicumarol. The present much greater use of the anticoagulant drugs has been paralleled by advances in surgical procedures for control of venous thrombosis. The panel to be presented is intended to review and correlate all these phases. A summary of the incidence, clinical types, morbidity, mortality, and pathogenesis of venous thrombosis will be given by the moderator of the panel as a prelude to the presentations by the collaborators.

Paper No. 28:

Venography, Advantages and Limitations—Earl R. Miller, M.D., University of California Hospital, San Francisco.

The technique of venography and the meaning of some of its results will be discussed.

Paper No. 29:

The Blood Clotting Mechanism and Tests for Its Efficiency—Roy W. Hammack, M.D., 657 South Westlake Avenue, Los Angeles.

The Factors Involved in Coagulation. The Source and Properties of Prothrombin. The Formation of Thrombin and the Nature of its Action. The Purpose of Coagulation. Practical Laboratory Methods for Estimation of Prothrombin and Coagulation time.

Paper No. 30:

The Use of Anticoagulants Heparin and Dicumarol—Salvatore P. Lucia, M.D., University of California Hospital, San Francisco.

A discussion of the mechanism of action of anticoagulants in general, and heparin and dicumarol in particular, with details of the technique of administration.

Paper No. 31:

The Physical Management of Phlebothrombosis and Thrombophlebitis—Leon Goldman, M.D., and Stanley G. Johnson, M.D., University of California Hospital, San Francisco.

A report of phlebothrombosis and pulmonary embolism in postoperative and medical patients seen at the San Francisco Hospital during the past three years. The indications and techniques of femoral and iliac vein ligation will be discussed.

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Fourth Meeting

Thursday, May 9, 1:30 p.m.

General Session, in Joint Meeting with Sections on General Medicine and General Surgery

CLINICAL-PATHOLOGICAL CONFERENCE

Three Case Histories—Under joint chairmanship of William Kroger, M.D., of Los Angeles, and S. P. Lucia, M.D., of San Francisco.

Paper No. 32:

Case No. 1: Pathologist James Rinehart, M.D., University of California Hospital, San Francisco; with clinician Allan T. Kenyon, M.D., University of Chicago Medical School, Chicago.

Paper No. 33:

Case No. 2: Pathologist Hugh Edmondson, M.D., Los Angeles County General Hospital, Los Angeles; with clinician Verne Mason, M.D., 523 West Sixth Street, Los Angeles.

Paper No. 34:

Case No. 3: Pathologist Gilbert Curtis, M.D., 1200 North State Street, Los Angeles, with clinician J. Homer Woolsey, M.D., Woodland Clinic, Woodland.

III

OBSTETRICS AND GYNECOLOGY SECTION

Meeting Room: Conference Room No. 1, on Mezzanine Floor, off North Galeria

Daniel G. Morton, M.D., *Chairman*
University of California Hospital, San Francisco
Philip A. Reynolds, M.D., *Vice-Chairman*
1930 Wilshire Boulevard, Los Angeles
T. Floyd Bell, M.D., *Secretary*
431 Thirtieth Street, Oakland

First Meeting

Tuesday, May 7, 1:30 p.m.

Joint Meeting with Section on Urology First Half

Paper No. 66:

Pyelitis in Pregnancy—W. Dayton Clark, M.D., Stanford University Hospital, San Francisco.

(a) Physiological changes in urinary tract during pregnancy; (b) The clinical disease entity, including bacteriology, pathology, and radiographic findings; (c) Treatment: Preventive, ambulatory, hospital, during labor and puerperium. Termination of pregnancy. Methods of delivery at term; (d) Sequellae and future pregnancies.

Discussion by Paul A. Ferrier, M.D., Pasadena.

Paper No. 67:

Renal Contra-indications to Pregnancy—Thomas E. Gibson, M.D., 450 Sutter Street, San Francisco.

An evaluation of renal factors both relative and absolute, which are inimical to pregnancy.

Paper No. 68:

The Post-Partum Bladder—George E. Judd, M.D., 1930 Wilshire Boulevard, Los Angeles, and Frederick A. Bennetts, M.D., 11241 Blix Street, North Hollywood.

In September, 1941, a report was prepared covering the study of the bladder, postpartum, made at the Los Angeles County General Hospital. The study was based upon the cystoscopic and cystometric findings of the postpartum patient. A report of these findings was made in the *American Journal of Obstetrics and Gynecology,* 1941.

Certain questions were raised at that time for further investigation. Some of these have been answered, and additional information has been secured. It is in the interest of the continuation of the study of this phase of Obstetrics and Urology that the paper will be presented.

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Business Recess

Business Meeting and Election of Officers

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Second Meeting

Wednesday, May 8, 9:30 a.m.

Meeting Room: Conference Room No. 1, on Mezzanine Floor, off North Galeria

Joint Meeting with Section on Pathology and Bacteriology

SYMPOSIUM ON THE RH FACTOR

Paper No. 69:

Moderator: Charles W. Leach, M.D., San Francisco.

Paper No. 70:

Obstetrics—Philip A. Reynolds, M.D., 1930 Wilshire Boulevard, Los Angeles.

Presenting the problem as it applies to the obstetrician.

Paper No. 71:

Hematology and Treatment — Madeleine A. Fallon, M.D., 1930 Wilshire Boulevard, Los Angeles.

The management of the erythroblastic infant.

Paper No. 72:

Pathology—Roy W. Hammack, M.D., 657 South Westlake Avenue, Los Angeles.

The pathological changes in erythroblastosis.

Paper No. 73:

Serology—Roy Fisk, Ph.D., Huntington Memorial Hospital, Pasadena. (By invitation.) The blood findings in erythroblastosis.

Questions, in writing, may be submitted to the Moderator during the meeting.

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Second Half of Program

Paper No. 74:

The Recurrence of Ovulation Following Parturition—Robert Lyon, M.D., University of California Hospital, San Francisco, and Mary J. Stamm, M.D., University of California Hospital, San Francisco.

The time of the resumption of both menstruation and ovulation has been studied in thirty-two puerperal patients. These cases were divided into those who lactated five months or more, those lactating one month and those who did not lactate at all. The evidence presented was gathered by means of basal body temperature and endometrial biopsies, correlated with various phases of the puerperal convalescence.

Paper No. 75:

Demorol Analgesia in Obstetrics—Alexis G. Maximov, M.D., 576 B Street, Santa Rosa.

Demorol and Scopolamine have been used in a series of 300 cases at the Sonoma County Hospital during the past fifteen months. The percentage of satisfactory results is reported, and the dosage scheme discussed. The effect of Demorol and Scopolamine on length of labor and on the mother and fetus are noted.

Discussion by Charles Isham, M.D., San Diego.

Paper No. 76:

Psychosomatic Aspect of Dysmenorrhea—William E. Hunter, M.D., and Bruce B. Rolf, M.D., 1033 Gayley Avenue, Los Angeles.

Dysmenorrhea is a symptom complex that occurs most often in normal healthy ovulating girls with lowered pain threshold.

A discussion of the mechanism of "Phantom Patterns" of exaggerated moliminal symptoms in the psychosensory areas in the cerebral cortex, by the summation of multiple inadequate stimuli and enhanced by monthly repetition.

Discussion by Roy M. Dorcus, Professor of Psychology, U.C.L.A.

Paper No. 77:

Chairman's Address—Daniel G. Morton, M.D., University of California Hospital, San Francisco.

Paper No. 78:

Five Year Series of Chronic Salpingitis at the Los Angeles General Hospital—H. N. Shaw, M.D., and John Gaspar, M.D., 901-2 Pacific Mutual Building, Los Angeles.

A study of thirty-five hundred cases of chronic salpingitis admitted to the Los Angeles General Hospital during the past five years. An attempt to evaluate the results of treatment with sulfonamides and penicillin, and comparing those results with our experience of former years.

Discussion by John Gaspar, M.D., Los Angeles.

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IV

EYE, EAR, NOSE AND THROAT SECTION

Meeting Room: Conference Room No. 1, on Mezzanine Floor, off North Galeria

Lewis F. Morrison, M.D., *Chairman*
490 Post Street, San Francisco

Dohrmann K. Pischel, M.D., *Vice-Chairman*
490 Post Street, San Francisco

Pierre Viole, M.D., *Secretary*
1930 Wilshire Boulevard, Los Angeles

Section Aides:

Colby Hall, M.D., Los Angeles
John Lordan, M.D., Los Angeles

First Meeting
Wednesday, May 8, 1:30 p.m.
In Conference Room 1

Paper No. 79:

Disorders of Visual Perception and Interpretation—John A. Bullis, M.D., 1241 Shatto Place, Los Angeles.

A presentation of some disorders of visual perception including mind blindness, visual memory, and interpretation of visual phenomena resulting from lesions of the central nervous system.

Discussion by J. M. Nielsen, M.D., Los Angeles.

Paper No. 80:

Cyclodialysis, Multiple or Single, with Air Injection: An Operative Technique for Chronic Glaucoma of the Wide Angle Type—Otto Barkan, M.D., 490 Post Street, San Francisco.

The objective of the method described is to make a larger dialysis with less trauma than is possible with the ordinary technique of cyclodialysis, and to control hemorrhage. Multiple cyclodialysis with air injection is at once a safer and more effective operation than a single cyclodialysis according to the usual method. The results in a series of 80 operations are given.

Discussion by David O. Harrington, M.D., San Francisco, and John Lordan, M.D., Los Angeles.

Paper No. 81:

Ophthalmology Notes from the European Theater—Clinton A. Wilson, M.D., 609 South Grand Street, Los Angeles.

1. Type and frequency of injuries related to the activity of the individual, battle and non-battle.

2. Diseases related to warfare: conjunctivitis, iritis, corneal ulcer, glaucoma in: (a) U. S. and Allied troops; (b) recovered Allied military personnel; (c) displaced personnel; (d) prisoners of war and German civilians.

3. Treatment: (a) early for injuries, and with special attention to use of penicillin and tetanus toxoid; (b) safety measures; (c) adequate food and hygiene.

4. The British Ophthalmic and Optical Unit.

5. Essentials of re-orientation for the eye surgeon working in forward areas.

Discussion by George S. Campion, M.D., San Francisco.

Paper No. 82:

The Treatment of Alternating Convergent Strabismus in Infancy—Avery Morley Hicks, M.D., 490 Post Street, San Francisco.

Alternating convergent strabismus frequently develops in those cases of strabismus which have their onset during the first six months of life. It is more apt to occur if the errors of refraction are small and of equal amount. The prognosis from treatment of this type of strabismus is relatively poor unless carried out in early childhood. This is a review of the motor and sensorial symptoms in a series of twenty-five cases treated by continuous permanent alternating occlusion of the eyes from the age of one year until the deviations were corrected surgically at about the age of two years.

Discussion by W. E. Borley, M.D., San Francisco.

Paper No. 83:

Deficiency Diseases of the Eye—Warren A. Wilson, M.D., 1930 Wilshire Boulevard, Los Angeles.

In a Prison of War Camp of approximately six thousand Americans between five hundred and one thousand patients were observed suffering from Xerophthalmia. Of this group a hundred were cared for that had developed Keratomalacia. The diet therapy, routine and results of these cases will be discussed. In addition, over a thousand cases of Amblyopia were examined and treated. This condition was caused by retrobulbar neuritis due to nutritional deficiencies. These will be discussed in detail.

Discussion by Max E. Pohlman, M.D., Los Angeles.

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Second Meeting
Thursday, May 9, 1:30 p.m.

Meeting Room: Conference Room No. 1, on Mezzanine Floor, off North Galeria

Paper No. 84:

Epiglottitis—Alden H. Miller, M.D., 500 South Lucas Avenue, Los Angeles.

A clinical consideration of the etiology of acute infections of the epiglottis based on cases seen in the Los Angeles County Hospital, Children's Hospital and Eye and Ear Hospital.

The greatest interest lies in etiology. Epiglottitis may be primary, as following trauma, but usually is part of an upper respiratory infection, especially streptococcal and influenzal infections. The latter, in children, seems to give almost typical findings. Early diagnosis, recognition of possible extension obstructing the larynx, and treatment is stressed.

Discussion by Simon Jesberg, M.D., Los Angeles.

Paper No. 85:

Tuberculosis of the Tonsil and Adenoid: a Bacteriologic and Microscopic Study of Material from 500

Consecutive Tonsillectomies and Adenoidectomies in Children—Ernest R. V. Anderson, M.D., 1052 West Sixth Street, Los Angeles.

1. Tuberculin tests were performed in 500 children to have tonsillectomy and adenoidectomy at the Los Angeles General Hospital. In those cases in which the tuberculin reaction was positive, the tonsils and adenoids were examined histologically for tuberculosis, and by culture and animal inoculation for tubercle bacilli.

2. The age range was from 2 to 17 years with an average of 9 years. Of the 500 cases, 118 or 23.6 per cent were tuberculin positive. Four cases were histologically positive, 7 cases were bacteriologically positive. Histological and bacteriological findings were present together in three. Tuberculosis or tubercle bacilli were found in 8 cases.

3. Chest roentgenography in the cases with tonsillar findings showed no disease in one, inconclusive findings in one, calcified hilar nodes in 5, and active tuberculosis in one.

4. Gastric washings combined with material obtained by pharyngeal swabbing were examined by culture and animal inoculation in the 8 cases with tonsillar findings. The results were negative for tubercle bacilli in 7, positive in one. The one positive was the same as that showing active disease by x-ray.

Discussion by C. Richard Smith, M.D., Los Angeles.

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Business Recess

Business Meeting and Election of Officers

Paper No. 86:

The Relation of Deep Roentgen Therapy to Aero-otitis—Francis O'N. Morris, M.D., 211 Cherry Avenue, Long Beach.

While attached to the Air Corps, experimental work was done with irradiation of the eustachian tube tissue in an effort to minimize the grounding of flying personnel with persistent aero-otitis media. The rationale behind radiation therapy is discussed with the two types, namely, radium and deep x-ray, being separated. We used deep x-ray radiation because of the homogeneous dosage to the entire eustachian tube. Our dosage is given with the reason therefor. A discussion of the criteria or indication for such therapy for persistent aero-otitis is also given. Three typical case histories and the results are discussed in detail with one case illustrating the importance of ruling out psychoneurosis. Furthermore, a chart is compiled of different patients with their complaints; absence or presence of tonsils and adenoids, nasopharyngoscopic examination, the roentgen dosage, the hearing, and the disposition.

Discussion by Arthur H. Rice, M.D., Berkeley, and Leland Hunnicutt, M.D., Pasadena.

Paper No. 87:

Further Experiences in the Evolution of the Lempert Fenestration Operation: A Preliminary Report—Sylvan S. Goldberg, M.D., 1917 Wilshire Boulevard, Los Angeles.

A short history of Lempert's work and fenestration surgery is given from the beginning up to the present time.

A preliminary report of the author's experiences in an attempt to, first, institute a means of inhibiting bone regeneration. This is attempted by the use of a Tantalum insert into the window in the labyrinth and, second, by the use of depressing doses of Anti-Reticular Cytotoxic Serum—the so-called Russian Serum.

A preliminary report on the author's experience in attempting to reduce the prolonged postoperative discharge by the construction of a modified Panse flap is described.

Discussion by Howard House, M.D., Los Angeles.

Paper No. 88:

Repair of Post-auricular Fistula Through the Endaural Approach—Howard House, M.D., 1136 West Sixth Street, Los Angeles.

A motion picture.

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V

ANESTHESIOLOGY SECTION

Charles J. Betlach, M.D., *Chairman*
3326 Calle Noguerra, Santa Barbara

John A. Stiles, M.D., *Secretary*
Stanford University Hospital, San Francisco

First Meeting—First Half

In Ball Room, at South End of North-South Galeria
Wednesday, May 8, 1:30 p.m.
Ball Room

Joint Meeting With Section on General Surgery

Paper No. 57:

Physiology of Traumatic Reflexes and Respiration During Surgical Anesthesia: Quantitative and Pneumographic Studies Under Pentothal and Local Nerve Block—James C. McCann, M.D., Worcester, Massachusetts.

This study is based on the hypothesis that anesthesia under sodium pentothal establishes in the human the basic experimental condition of "functional decerebration." Reflex arcs to the infracerebral nerve centers are preserved intact during surgical planes of anesthesia. This permits accurate physiological observations of the reflex stimulation of respiration by surgical pain stimuli. Studies of the rate of utilization of pentothal in general surgery revealed that the major factor determining the quantitative use of pentothal was the intensity of the reflex stimulation of the respiratory center by surgical trauma. The pain impulses have been interrupted strategically with direct procaine nerve block, and the rate of utilization of pentothal sharply reduced. Clinical observations were made of specific reflex respiratory responses to trauma from segmental areas of the body (cervical, thoracic, lumbar, sacral) with pneumograms. Demonstration of the segmental specificity of different types of reflex respiratory response was thus established. Counterproof of their specificity and character was accomplished by blocking out the specific areas with procaine nerve block and repeating the pneumograms. Thus in the human an experimental study of the physiology of surgical anesthesia has been made. The results appear to be of significance whatever the anesthetic agent used.

Recess

* * *

Second Half

Conference Room No. 4, on Mezzanine Floor, off North Galeria

Paper No. 89:

Chairman's Address—Acute Pulmonary Edema During Anesthesia—Charles J. Betlach, M.D., 3326 Calle Noguerra, Santa Barbara.

A case of acute pulmonary edema during anesthesia and surgery reported with a discussion of possible contributing factors.

Discussion by Ernest H. Warnock, M.D., Santa Barbara.

Paper No. 90:

Observations in Patients Undergoing Prolonged Anesthetic Procedures—Thomas A. Broderick, M.D., 2152 Bay Street, San Francisco.

Deals with the sequence of anesthetic agents used in prolonged surgical cases in an Army General Hospital; the support of these patients by parenteral therapy, and the indications for such support. The immediate post-anesthetic period and its management.

Discussion by William B. Neff, M.D., San Francisco.

Paper No. 91:

Regional Anesthesia for Emergency Surgical Procedures—Charles F. McCuskey, M.D., 1561 Puebla Drive, Glendale.

The choice of anesthesia for emergency operations where shock is a preoperative factor, must be based on the effects of the anesthetic agent and method on the pre-existing shock. For many conditions, regional anesthesia alone or combined with inhalation or intravenous anesthesia, offers the patient the widest margin of safety.

Discussion by John Grimm, M.D., Santa Monica.

Second Meeting
Thursday, May 9, 1:30 p.m.

Meeting Room: Conference Room No. 4, on Mezzanine Floor, off North Galeria

Paper No. 92:

Parenteral Fluid Therapy During Prolonged Surgery—Gordon C. Langsdorf, M.D., 210 Medico-Dental Building, San Diego.

The administration of blood, plasma, and other fluids during prolonged surgical procedures is discussed. Observations are based on experience with anesthesia during reconstructive operations at a military hospital during the recent war.

Discussion by Captain William Bishop (MC), Pasadena Regional Hospital, Pasadena.

Paper No. 93:

Anesthesia for the Chronic Poliomyelitis Patient—Neil H. Lewis, M.D., 212 North Wilton Place, Los Angeles.

Three hundred fifty anesthetics on chronic or "old" poliomyelitis patients are reviewed. Because of respiratory muscular weakness the patient must be examined carefully preoperatively. His premedication should be minimal. The anesthetic should be of a respiratory stimulating type such as gas-ether. Intravenous Sodium Pentothal for minor procedures may also be used with oxygen by mask.

Discussion by Harvey E. Billig, M.D., Los Angeles.

Business Recess

Business Meeting and Election of Officers

Paper No. 94:

Nitrous Oxide Anesthesia with Curare Relaxation—William B. Neff, M.D., and Edward C. Mayer, M.D., Stanford University Hospital, San Francisco.

Nitrous oxide with oxygen in atmospheric proportions or higher and combined with curare to provide relaxation may afford good anesthesia. The safety of the technique depends upon the anesthetist's knowledge of the problems of ventilation which are discussed.

Discussion by Bruce Anderson, M.D., Oakland.

Paper No. 95:

Spinal Anesthesia and Obstetrics—David N. Treweek, M.D., 1112 North La Cienega, Los Angeles.

The advantages of small dosages of spinal anesthetic agents in obstetrical cases at term.

Discussion by A. J. Wineland, M.D., Los Angeles.

VI

DERMATOLOGY AND SYPHILOLOGY SECTION

Clement E. Counter, M.D., *Chairman*
117 East Eighth Street, Long Beach

Charles J. Lunsford, M.D., *Vice-Chairman*
3115 Webster Street, Oakland

Arthur Fletcher Hall, M.D., *Secretary*
710 Wilshire Boulevard, Santa Monica

First Meeting
Thursday, May 9, 9:30 a.m.
First Half

Meeting Room: Conference Room No. 1, on Mezzanine Floor, off North Galeria

Joint Meeting with Section on Public Health

SYMPOSIUM ON SYPHILIS

(Round Table Discussion)

Paper No. 96:

Moderator: J. R. Scholtz, M.D., formerly Lt. Col., A.U.S., M.C., Chief of Dermatology Branch, Office of Air Surgeon, Hdg., A.A.F.

Paper No. 97:

Thomas H. Sternberg, M.D., formerly Lt. Col. (MC), A.U.S., Chief of V.D. Control Div., Office of Surgeon General.

Paper No. 98:

Robert Dyar, M.D., formerly Lt. Col. (MC), A.U.S., Chief of V.D. Control, Office of Air Surgeon, Hdg., A.A.F.

Public Health Implications of Modern Treatment. The public health implications in the newer methods of treatment of venereal disease, such as changes in the public attitude towards syphilis, increased likelihood of reinfection, "masked" infections, etc., will be discussed.

Paper No. 99:

Hiram Newton, M.D., formerly Commander (MC), U.S.N.R., 1203 Bank of America Building, San Diego.

There are advantages and disadvantages in the penicillin treatment of syphilis. These have to do with time lost by the patient in treatment; expense to the patient for treatment; Public Health aspects, and the question of efficiency.

Paper No. 100:

Rapid Teratment of Early Syphilis with Combined Penicillin, Mapharsen, Bismuth—John F. Flynn, Jr., M.D., Medical Officer in Charge, Los Angeles County Rapid Treatment Center, Los Angeles.

A presentation of the use of combined Penicillin, Mapharsen, and Bismuth in the rapid treatment of early syphilis as developed in the Rapid Treatment Center program of the U. S. Public Health Service. Treatment methods, reactions to treatment, post-treatment follow-up of patients, and treatment results available to date will be reviewed.

Paper No. 101:

Penicillin in the Treatment of Late Syphilis—C. Russell Anderson, M.D., 1930 Wilshire Boulevard, Los Angeles.

The present status and possible future use of penicillin in the treatment of late syphilis will be discussed.

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Second Meeting

Meeting Room: Conference Room No. 2, on Mezzanine Floor, off North Galeria

Thursday, May 9, 1:30 p.m.

Joint Meeting With Section on Public Health

SYMPOSIUM ON UNTOWARD EFFECTS OF ATABRINE

Paper No. 102:

Atabrine Dermatitis—Thomas W. Nisbet, M.D., 65 North Madison Avenue, Pasadena.

A brief clinical description of cutaneous manifestations occurring in troops in the Southwest Pacific area following the prolonged administration of atabrine. Kodachrome lantern slides illustrating the various types of eruptions will be shown. Dr. Nisbet will present the general orientation on the subject.

Paper No. 103:

Atabrine Dermatitis and Associated Aplastic Anemia—James R. Drake, M.D., 490 Post Street, San Francisco, and Capt. Henry D. Moon (MC), A.U.S.

Part I: A brief clinical and histopathological description of three types of cutaneous reaction to atabrine as seen in Army general hospitals; a discussion of etiology and treatment of atabrine dermatitis.

Part II: Seventeen cases coming to autopsy are discussed, presenting skin lesions, aplastic anemia and/or acute yellow atrophy of the liver. Hematologic findings are tabulated.

Paper No. 104:

Atypical Lichenoid Dermatitis Due to Atabrine—Richard O. Pfaff, M.D., Medico-Dental Building, San Jose.

This paper will consist of a brief résumé of the dermatologic aspects of dermatitis due to atabrine, with special references to the Lichenoid type.

Paper No. 105:

Untoward Effects of Atabrine—Albert G. Bower, M.D., 60 S. Grand Avenue, Pasadena.

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Third Meeting

Meeting Room: Conference Room No. 9, on Mezzanine Floor, off North Galeria

Friday, May 10, 9:00 a.m.

Paper No. 106:

Tropical Acne—Frederick G. Novy, Jr., M.D., 2938 McClure Street, Oakland.

This paper deals with what turned out to be one of the most common and serious dermatological problems in Navy personnel. One hundred consecutive cases returning from overseas because of this condition are analyzed.

Discussion by W. W. Deumling, Comdr. (MC), U.S.N.R., San Diego, and Herman Allington, M.D., Oakland.

Paper No. 107:

Cheese Mite Dermatitis—Harold C. Fishman, M.D., 2007 Wilshire Boulevard, Los Angeles.

A case is reported and illustrated with lantern slides. This is believed to be the first case reported of American origin and from American made cheese.

Discussion by Frances A. Torrey, M.D., San Francisco.

✣

Business Recess

Business Meeting and Election of Officers

Paper No. 108:

Skin Manifestations of Rheumatic Fever—George C. Griffith, M.D., Postgraduate School of Medicine, University of Southern California, Los Angeles.

This paper reports the skin lesions in more than 10,000 cases of rheumatic fever. Dermatologic manifestations regarded as definitely related, and those regarded as coincidental are differentiated and discussed.

Discussion by J. R. Scholtz, M.D., Los Angeles.

Paper No. 109:

Cutaneous Reactions to Penicillin—Ben A. Newman, M.D., 1242 Hipoint Street, Los Angeles.

This paper reports and considers dermatologic manifestations of sensitization to penicillin administered by injection, ingestion and topical application.

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VII

INDUSTRIAL MEDICINE AND SURGERY SECTION

JOHN E. KIRKPATRICK, M.D., *Chairman*
516 Sutter Street, San Francisco

RICHARD J. FLAMSON, M.D., *Vice-Chairman*
523 West Sixth Street, Los Angeles

KEENE O. HALDEMAN, M.D., *Secretary*
350 Post Street, San Francisco

Section Aides:

JOHN D. BALL, M.D., Santa Ana
BENJAMIN M. FREES, M.D., Los Angeles

First Meeting

Tuesday, May 7, 1:30 p.m.

Meeting in Ball Room—At South End of North-South Galeria

Joint Meeting with Section on General Surgery

PANEL DISCUSSION ON SURGERY OF THE HAND

Chairman of Panel: Sterling Bunnell, M.D.

(See Papers 52-56)

Anatomy of the Hand, with Emphasis on the General Mechanism and Special Emphasis on the Finger Mechanism, and Influence of Muscles in Fractures of the Hand—Jacob Janzen, M.D., 312 North Boyle Avenue, Los Angeles.

Primary Treatment of Open Wounds of the Hand—John E. Kirkpatrick, M.D., 516 Sutter Street, San Francisco.

Infection of the Hand with Evolution of Chemotherapy—Joseph H. Boyes, M.D., 1401 South Hope Street, Los Angeles.

Amputation of the Hand and Fingers—Vernon P. Thompson, M.D., 860 South Hudson, Los Angeles.

Treatment and Prevention of Stiff Joints of the Hand and Fingers, Including Trophic Disorders—Major Donald Pratt (MC), Dibble General Hospital, Menlo Park.

General discussion.

Second Meeting

Wednesday, May 8, 1:30 p.m.

Meeting Room: Conference Room No. 8, on Mezzanine Floor, off North Galeria

Paper No. 110:

Sciatic Neuritis—The Pronation Syndrome: A Different Cause and Treatment—Laurence Jones, M.D., 9615 Brighton Way, Beverly Hills.

Twenty-six cases of sciatic neuritis, all seen within the last two and one-half years will be reported. All save one were successfully treated by a simple conservative nonoperative method. This will be described and five illustrative case histories given. All have been closely followed and there have been no recurrences to date.

Discussion by O. W. Jones, Jr., M.D., San Francisco and R. B. Raney, M.D., Los Angeles.

Paper No. 111:

Psychiatric Aspects of Industrial Accidents—Arthur J. McDowell, M.D., 870 Market Street, San Francisco.

Psychiatric evaluation of industrial accident casualties, as a group, establishes the presence of personality deficiencies antedating the accident.

Traumatic neurosis following minor trauma in such cases is, at most, but an aggravation of a preexisting weakness, not permanent and not totally disabling. The cause and effect relationship should be made undeniably clear.

General discussion.

Business Recess

Business Meeting and Election of Officers

Paper No. 112:

A Discussion of Wound Metabolism—John L. Gallagher, M.D., 233 A Street, San Diego.

Whenever a serious traumatic injury occurs to an area of the body there follows a disturbance of the local cellular metabolism and of the general body metabolism to a degree depending upon the extent of the injury, the nature of the after care and other conditions. A study of the various types of wounds is made from the metabolic viewpoint, its influence on the treatment of the wound and the general condition of the patient. (With slides.)

Discussion by William S. Kiskadden, M.D., Los Angeles, and James B. Johnson, M.D., Los Angeles.

Paper No. 113:

Mechanics of the Shoulder Joint—Verne T. Inman, M.D., University of California Hospital, San Francisco, and John B. de C. M. Saunders, M.D., University of California Hospital, San Francisco.

In order to establish a rational basis for the surgery of the shoulder joint exhaustive studies have been carried out on its mechanism. A brief discussion of scapulo-humeral rhythm and its relationship to that of the clavicle together with its clinical significance will be taken up.

General discussion.

Paper No. 114:

Rehabilitation of the Industrially Injured—John J. Loutzenheiser, M.D., 350 Post Street, San Francisco.

Medicine is charged with a continuing responsibility for the accomplishment of the physical and psychic rehabilitation of the industrial injured. This obligation is not met by casual use of physical therapy and occupational therapy. The need for and function of a Rehabilitation Unit or Center is emphasized.

Discussion by Francis M. McKeever, M.D., Los Angeles, and Vernon P. Thompson, M.D., Los Angeles.

VIII

NEUROPSYCHIATRY SECTION

Meeting Room: Conference Room No. 4, on Mezzanine Floor, off North Galeria

HERBERT E. CHAMBERLAIN, M.D., *Chairman*
P. O. Box 933, Sacramento

ARTHUR R. TIMME, M.D., *Secretary*
1930 Wilshire Boulevard, Los Angeles

Section Aides:

KARL VON HAGEN, M.D., Los Angeles
EDWARD TWITCHELL, M.D., San Francisco

First Meeting

Wednesday, May 8, 9:00 a.m.

Paper No. 115:

The Anxiety States and Their Treatment—Cullen W. Irish, M.D., 1930 Wilshire Boulevard, Los Angeles.

Anxiety reactions usually result from long continued or acute excessive stresses. Adequate psychotherapy is the basic effectual therapeusis, enhanced by correction of physical dysfunctions and promotion of proper metabolism and general physical well-being.

Discussion by Forrest N. Anderson, M.D., Los Angeles.

Paper No. 116:

Indications for the Use of Electroshock Treatment in Out-Patients—Byron Stewart, M.D., 9629 Brighton Way, Beverly Hills.

Many patients can be adequately treated by electroshock as out-patients. There are indications and contraindications for this procedure outside the financial saving through avoidance of sanitarial confinement.

Discussion by Clarence W. Olsen, M.D., Los Angeles.

Paper No. 117:

Psychoneurosis Based on Organic Ailment Cured by Electric Shock Therapy—D. R. Sears, M.D., 25 Twenty-fifth Avenue, San Mateo.

From a series of seven thousand electric shock treatments, it was found in reactive depressions, resulting from organic disability, usually typified by hypochondriasis, excellent results were obtained by electric shock therapy. Three such cases are presented.

Discussion by George Johnson, M.D., San Francisco, and Ernest G. Lion, San Francisco.

Paper No. 118:

Experimental Reproduction of Specific Wave Patterns in Electroencephalography—Clemson Marsh, M.D., White Memorial Hospital, Los Angeles.

The wave patterns in the electroencephalogram are the result of a mixture of frequencies of varied potential arising in the nuclear masses of the brain. These patterns are recorded without specific indication as to their exact source. By the experimental reproduction of the various wave types the separate components of each wave may be analyzed.

Discussion by H. Sjaardema, Ph.D. (by invitation).

Paper No. 119:

Glancing Gunshot Wounds of the Skull: A Point of Reference for Discussion of Cerebral Localization and Function—Hans von Briesen, M.D., 1930 Wilshire Boulevard, Los Angeles.

Several cases illustrate local loss of reception from and expression to the environment. They are utilized with diagrams and brain sections to explain cerebral localization and function. The Concept of Mind per se is questioned by implication. Lantern slides.

Discussion by J. M. Nielsen, M.D., Los Angeles.

Second Meeting

Thursday, May 9, 1:30 p.m.

Meeting Room: Conference Room No. 5, on Mezzanine Floor, off North Galeria

Paper No. 120:

Chairman's Address—Some Features of Psychiatric Practice in Postwar Medical Care Planning—Herbert E. Chamberlain, M.D., P. O. Box 933, Sacramento.

Factors which influence the acceptance, application and extension of psychiatric practice as related to wartime effort and postwar planning are briefly presented. An outline for community wide orientation is offered.

Business Recess

Business Meeting and Election of Officers

Paper No. 121:

The Value of the Rorschach Test in Psychiatric Diagnosis and Prognosis—Charlotte Buhler, Ph.D., 916 South Westlake Avenue, Los Angeles (by invitation).

In spite of many problems that the use of the Rorschach method still offers, we can notice a continuous progress in its successes. The main problems lie in the complexity of the method and in the difficulty to establish sufficiently reliable objective standards for prognosis of interpretation of results. Successful attempts are being made to overcome these difficulties. Author will report about the present status of her own standardization work and will evaluate the diagnostic and prognostic possibilities of this test.

Discussion by George N. Thompson, M.D., Los Angeles.

Paper No. 122:

Convulsions as a Protective Phenomenon—Eugene Ziskind, M.D., 2007 Wilshire Boulevard, Los Angeles.

Muskens thought that convulsions served a protective function which was to detoxify the organism. This concept is subjected to experimental verification. Animals were given alcohol. Half of the specimens received convulsions; and other half were controls. Blood alcohol and behavior notations were recorded.

Discussion by Henry Newman, M.D., San Francisco; Robert B. Aird, M.D., San Francisco; and Samuel D. Ingham, M.D., Los Angeles.

Paper No. 123:

Babinski's Reflex—Robert Wartenberg, M.D., University of California Hospital, San Francisco.

Methods of elicitation and physiologic interpretation. A critical review on the occasion of the 50th anniversary of its discovery, February 22, 1896. (Lantern slides.)

Discussion by A. R. Timme, M.D., Los Angeles.

IX

PATHOLOGY AND BACTERIOLOGY SECTION

R. H. Osborne, M.D., *Chairman*
312 North Boyle Avenue, Los Angeles

John J. Hawthorne, M.D., *Secretary*
3698 California Street, San Francisco

H. A. Edmondson, M.D., *Assistant Secretary*
1200 North State Street, Los Angeles

Section Aides:
C. S. Small, M.D., Loma Linda
A. A. Kosky, M.D., Santa Monica

First Meeting—First Half

Wednesday, May 8, 9:00 a.m.

Meeting Room: Conference Room No. 1, on Mezzanine Floor, off North Galeria

Joint Meeting With Sections on Obstetrics and Gynecology and Pediatrics

Symposium on the Rh Factor

(See Papers 69-73)

First Meeting—Last Half

Meeting Room: Conference Room No. 5, on Mezzanine Floor, off North Galeria

Paper No. 124:

The Diagnosis of Sarcoidosis—William H. Carnes, M.D., Stanford University School of Medicine, San Francisco.

Sarcoidosis should be considered in the differential diagnosis of all cases of chronic painless lymphadlenopthy whether there are demonstrable lesions of the skin, bones and lungs or not. The diagnosis is not established by pathological examination alone but only in conjunction with the appropriate clinical and bacteriological evidence to eliminate other granulomatous infections.

Discussion by David A. Wood, M.D., San Francisco.

Paper No. 125:

Hydatidiform Mole and Theca Lutein Cysts—Jesse L. Carr, M.D., University of California School of Medicine, San Francisco.

A short case report.

Discussion by A. M. Moody, M.D., San Francisco.

Paper No. 126:

Asphyxial Death Secondary to Bronchial Occlusion Caused by Cryptococcus Neoformans—A. M. Moody, M.D., 631 O'Farrell Street, San Francisco.

This presentation will include the clinical and pathological aspects of Pulmonary Cryptococcosis in a Mexican male who died from asphyxiation. Lantern slides will be shown.

Discussion by Edward M. Butt, M.D., Los Angeles.

Paper No. 127:

Nomenclature in a General Tumor Registry—Isabella H. Perry, M.D., University of California School of Medicine, San Francisco.

For the analysis of compiled case records mechanical sorting by punch cards is the only practical method. Only by agreement on a common nomenclature for Tumor Registries can information be pooled; and constructive comparisons made between recording groups.

Discussion by Paul Michael, M.D., Oakland, and Lyell C. Kinney, M.D., San Diego.

Paper No. 128:

Methanol Poisoning—Emil Bogen, M.D., Olive View.

The variety of sources from which this poisoning may arise, the difficulties in its prevention, the frequency of imbibition of small amounts of methanol without toxic effects other than those of ordinary alcohol, and the rationale of recently suggested therapeutic measures will be presented on the basis of half a dozen clinic outbreaks and some animal experimentation.

Paper No. 129:

Comparative Roentgenographic and Microscopic Patterns in Bone Sarcomas—Ian MacDonald, M.D., 2007 Wilshire Boulevard, Los Angeles.

The variability of the Roentgenologic findings in bone sarcomas is accounted for by certain fundamental processes which occur in neoplasms of bone. Illustrated by slides.

Discussion by John W. Budd, M.D., Los Angeles.

✣

Second Meeting
Thursday, May 9, 9:00 a.m.

Meeting Room: Conference Room No. 4, on Mezzanine Floor, off North Galeria

Paper No. 130:

Chairman's Address — Granular Cell Myoblastoma — R. H. Osborne, M.D., 312 North Boyle Avenue, Los Angeles.

A partial review of the literature and case reports will be presented.

Paper No. 131:

Congestive Splenomegaly (Banti's Syndrome) Due to Portal Stenosis—Case Report and Notes—Dennis S. Shillam, M.D., Children's Hospital, Los Angeles.

Discussion by L. J. Tragerman, M.D., Los Angeles.

Paper No. 132:

The Effect of High and Low Protein Diets on the Toxic Effects of Sulfathiazole—Ralph Knutti, M.D., Children's Hospital, Los Angeles.

Under the conditions of the experiments, rats on high protein diets survived doses of sulfathiazole that uniformly killed partially protein depleted rats. The major lesions are discussed, as are the possible mechanisms. (With slides.)

Discussion by Ralph E. Homann, Jr., M.D., Los Angeles.

Paper No. 133:

Genitomammary Paraffinomata In the Male—Albert F. Brown, M.D., 318 North Central Avenue, Glendale, and Eugene J. Joergenson, M.D., 632 North Brand Boulevard, Glendale.

This is a report of subcutaneous oil tumors in bizarre locations.

Discussion by William O. Russell, M.D., Santa Barbara.

X

PEDIATRIC SECTION

Charles W. Leach, M.D., *Chairman*
2000 Van Ness Avenue, San Francisco
Chester I. Mead, M.D., *Secretary*
1930 Truxton Avenue, Bakersfield
Alice I. Potter, M.D., *Assistant Secretary*
2990 Jackson Street, San Francisco
Section Aides:

✣

First Meeting, Wednesday, May 8, 9:00 a.m.

Meeting Room: Conference Room No. 1, on Mezzanine Floor, off North Galeria
Joint Meeting with Sections on Obstetrics and Gynecology and Pathology and Bacteriology

SYMPOSIUM ON THE RH FACTOR

(See Papers 69-73)

Moderator: Charles W. Leach, M.D., San Francisco.

Obstetrics—Philip A. Reynolds, M.D., 1930 Wilshire Boulevard, Los Angeles.

Presenting the problem as it applies to the obstetrician.

Hematology and Treatment—Madeleine A. Fallon, M.D., 1930 Wilshire Boulevard, Los Angeles.

The management of the erythroblastic infant.

Pathology—Roy W. Hammack, M.D., 657 South Westlake Avenue, Los Angeles.

The pathological changes in erythroblastosis.

Serology—Roy Fisk, Ph.D., Huntington Memorial Hospital, Pasadena. (By invitation).

The blood findings in erythroblastosis.

Questions to be submitted to the Moderator in writing during the meeting.

✣

Second Meeting
Wednesday, May 8, 1:30 p.m.
Meeting Room: Conference Room No. 8, on Mezzanine Floor, off North Galeria

Paper No. 134:

Neurological Complications from Treatment with Rabies Vaccine in Cases Seen at the Los Angeles General Hospital—F. Hamilton Redewill, Jr., M.D., 235 North Greenleaf Avenue, Whittier, and Laurence J. Underwood, M.D., 2651 East Slauson Avenue, Huntington Park.

This paper will include a review of literature with a report on 6 cases seen on the contagious disease unit of the Los Angeles General Hospital covering the last five years—with a discussion of the vaccine treatment and methods against rabies.

Discussion by Paul Hamilton, M.D., San Marino, and Albert G. Bower, M.D., Pasadena.

Paper No. 135:

The Responsibility of the Pediatrician in the Orthodontic Problem—Francis M. Pottenger, Jr., North Canyon Boulevard, Monrovia.

This paper will deal with some of the fundamental causes of facial deformity, and ways and means of helping patients to avoid them. It will be illustrated with lantern slides showing early evidence of developing dental deformities. It will also include a discussion of dental deformity in relation to damage in other osseus structures. (With slides.)

Discussion by Dr. Cecil C. Steiner, Los Angeles (by invitation).

Paper No. 136:

Eczema in Infants and Children—Leon Z. Wolpe, M.D., 8706 Wilshire Boulevard, Beverly Hills.

This paper will deal with new observations on protein deficiency occurring in the course of infantile eczema illustrated with slides.

Discussion by Nelson Paul Anderson, M.D., Los Angeles.

Paper No. 137:

Congenital Adrenal Cortical Insufficiency with Macro-Genitosomia—H. E. Thelander, M.D., 384 Post Street, San Francisco.

A case of congenital adrenal cortical insufficiency (Addison's disease) has been followed over a period of six years and to the time of death, November, 1945. This child showed the classical syndrome of adrenal cortical insufficiency combined with androgen hyperproduction, resulting in acceleration of the bone age and the physical growth as well as sexual precocity. His mental development was normal. His death was due to measles with convulsions. (With slides.)

Discussion by William C. Deamer, M.D., San Francisco.

Paper No. 138:

Observations on an Epidemic of Diphtheria—William A. Reilly, M.D., 450 Sutter Street, San Francisco.

This paper deals with Army experience in Sicily in 1943-44 with 216 patients admitted to hospital care with sore throat and positive virulent cultures for diphtheria bacilli. Eighty-one had typical membranous lesions and 116 had follicular tonsilitis or pharyngitis. Many hundreds of contacts were cultured daily. There were some with skin lesions.

Extensive testing was done by tellurite media for cultures, sugars for fermentation, guinea pigs for virulence and Schick test for immunity.

There were 27 non-immune cases of active diphtheria; 19 received antitoxin with one complication of myocarditis and eight did not receive antitoxin.

Cases were seen early and adequately treated with antitoxin—50,000 to 100,000 units. There was one death and 3 complications of myocarditis and 3 of peripheral neuritis.

Sulfonamides were used to treat 5 with active disease, 4 of whom seemed to respond fairly well.

Healthy carriers carried for 8 days on the average, those with upper respiratory infections for 7 days and those with diphtheritic disease for an average of 21 days. Persistence of virulence was slightly shorter.

The epidemic was complicated by the necessity for moving carriers internationally. Other problems are discussed.

✣

Business Recess

Business Meeting and Election of Officers

Paper No. 139:

Acute Osteomyelitis in Children—Treatment and Results Obtained—Samuel S. Mathews, 327 East Regent Street, Los Angeles.

A review of the cases of osteomyelitis at the Children's Hospital in Los Angeles with special reference to treatment. There will be special emphasis on the present management of acute hematogenous osteomyelitis in children.

Discussion by J. D. Lyttle, M.D., Los Angeles.

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XI

RADIOLOGY SECTION

James B. Irwin, M.D., *Chairman*
1831 Fourth Avenue, San Diego

Gordon G. King, M.D., *Secretary*
Children's Hospital, San Francisco

First Meeting

Wednesday, May 8, 1:30 p.m.

Meeting Room: Conference Room No. 9, on Mezzanine Floor, off North Galeria

Paper No. 140:

Treatment of Carcinoma of the Breast at Stanford Hospital—Evelyn Siris, M.D., and Leonard Dobson, M.D., Clay and Webster Streets, San Francisco.

This paper is an analysis of 375 cases of breast carcinoma seen and followed in the Stanford University Hospital Tumor Clinic between 1926 and 1945. It includes cases treated by (1) surgery only; (2) radiation only; (3) preoperative irradiation; and (4) postoperative irradiation.

Discussion by Leo M. Levi, M.D., and O. N. Meland, M.D., Los Angeles.

Paper No. 141:

Simultaneous Radiographic and Gastroscopic Examination of the Stomach—Carlton L. Ould, M.D., and Morris E. Dailey, M.D., Third Avenue and Parnassus, San Francisco.

Radiograms were taken while the gastroscopist was visualizing important landmarks in the stomach. The radiograms were studied in an effort to understand the several factors influencing the changes in the gastric mucosa, both radiographically and gastroscopically. The blind areas in the stomach were also studied. Several interesting and helpful conclusions were drawn.

Discussion by Rudolf Schindler, M.D., Los Angeles.

* * *

Business Recess

Business Meeting and Election of Officers

Paper No. 142:

Roentgen Therapy of Benign Bone Cysts—Clayton R. Johnson, M.D., 301 East Hadley Street, Whittier.

Case reports showing response to x-ray therapy.

Discussion by Vernon P. Thompson, M.D., Los Angeles, and Ian MacDonald, M.D., Los Angeles.

Paper No. 143:

Roentgenology of Chronic Mastoiditis and Clinical Significance of Roentgen Findings—Harold A. Fletcher, M.D., 1010 B Street, San Rafael, and Frank S. Windholz, M.D., 350 Post Street, San Francisco.

Roentgen anatomy and pathology, technique of roentgen demonstration of the middle ear and of adjacent structures of the mastoid are presented. Cholesteatoma suppuration, destructive bone changes associated with it, and their identification on radiographs are presented in detail.

Discussion by G. R. Owen, M.D., Los Angeles.

* * *

Meeting of Pacific Roentgen Society

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Second Part of Program

Ball Room, at the South End of the North-South Galeria

Wednesday, 1:30 p.m.

Joint Meeting with Section on General Surgery

PANEL DISCUSSION OF CARCINOMA OF THE STOMACH

Chairman of Panel: Thomas F. Mullen, M.D.

(See Papers 60-65)

What Can the Internist Do to Get More Early Cases to the Surgeon?—Clayton D. Mote, M.D., 384 Post Street, San Francisco.

The Place of Gastroscopy in the Early Diagnosis of Cancer of the Stomach—Rudolf Schindler, M.D., 1052 West Sixth Street, Los Angeles.

Early Signs of Gastric Carcinoma as Demonstrated by the X-ray—Kenneth S. Davis, M.D., St. Vincent's Hospital, Los Angeles.

What Are the Recent Advances Made in the Surgical Treatment of Cancer of the Upper End of the Stomach?—Gunther Nagel, M.D., 2000 Van Ness Avenue, San Francisco.

What Are the Results of the Surgical Treatment of Cancer of the Stomach, and What Is the Place and Value of Palliation?—George T. Pack, M.D., 139 East 36th Street, New York City.

General Discussion. Questions to be passed in to the Moderator in writing, who will audit the same and distribute to the appropriate members of the panel.

✣

Second Meeting

Ball Room, at the South End of the North-South Galeria

Thursday, May 9, 9:00 a.m.

Joint Meeting with Sections on General Surgery and General Medicine

PANEL DISCUSSION ON PULMONARY SUPPURATION

Co-Moderators: Reginald Smart, M.D., 1136 West Sixth Street, Los Angeles, and Emile Holman, M.D., Stanford University Hospital, San Francisco.

(See Papers 22-26)

Robert R. Newell, M.D., Stanford University Hospital, San Francisco.

Sidney Shipman, M.D., 490 Post Street, San Francisco.

Stephen Dolley, M.D., 1930 Wilshire Boulevard, Los Angeles.

Paul C. Samson, M.D., 805 Highland Avenue, Piedmont.

This is to be a joint panel with members of the Sections on Radiology, Medicine, and Surgery participating. It is to be a discussion of a group of representative cases illustrating the various common types of pulmonary suppuration, with a consideration of diagnosis and treatment—both medical and surgical.

* * *

Second Part of Program

PANEL DISCUSSION ON PHLEBOTHROMBOSIS AND ITS MEDICAL AND SURGICAL MANAGEMENT

(See Papers 27-31)

Moderator: C. J. Berne, M.D., Los Angeles. He will open the discussion.

Phlebothrombosis and Thrombophlebitis—Introductory Comment—C. J. Berne, M.D., 1136 West Sixth Street, Los Angeles.

Venography, Advantages and Limitations—Earl R. Miller, M.D., University of California Hospital, San Francisco.

A Discussion of the Physiological Aspects and Laboratory Control of the Clotting Mechanism—Roy Hammack, M.D., 657 South Westlake Avenue, Los Angeles.

The Use of Anticoagulants Heparin and Dicumarol—Salvatore P. Lucia, M.D., University of California Hospital, San Francisco.

The Physical Management of Phlebothrombosis and Thrombophlebitis—Leon Goldman, M. D., and Stanley G. Johnson, M.D., University of California Hospital, San Francisco.

XII

UROLOGY SECTION

DUDLEY P. FAGERSTROM, M.D., *Chairman*
710 Medico-Dental Building, San Jose

FRANKLIN FARMAN, M.D., *Secretary*
727 West Seventh Street, Los Angeles

Section Aides:

JESSE L. BROCKOW, M.D., Los Angeles
BURTON K. BROCK, M.D., Los Angeles

First Meeting

Tuesday, May 7, 1:30 p.m.

Meeting Room: Conference Room No. 7, on Mezzanine Floor, off North Galeria

Joint Meeting with Section on Obstetrics and Gynecology

Paper No. 66:

Pyelitis in Pregnancy—W. Dayton Clark, M.D., Stanford University Hospital, San Francisco.

(a) Physiological changes in urinary tract during pregnancy; (b) the clinical disease entity, including bacteriology, pathology, and radiographic findings; (c) treatment: Preventive, ambulatory, hospital, during labor and puerperium. Termination of pregnancy. Methods of delivery at term; (d) sequellae and future pregnancies.

Discussion by Paul A. Ferrier, M.D., Pasadena.

Paper No. 67:

Renal Contra-indications to Pregnancy—Thomas E. Gibson, M.D., 450 Sutter Street, San Francisco.

An evaluation of renal factors—both relative and absolute, which are inimical to pregnancy.

Discussion by Tracy O. Powell, M.D., Hollywood.

Paper No. 68:

The Post Partum Bladder—George E. Judd, M.D., 1930 Wilshire Boulevard, Los Angeles, and Frederick A. Bennetts, M.D., 11241 Blix Street, North Hollywood.

In September, 1941, a report was prepared covering the study of the bladder, post-partum, made at the Los Angeles County General Hospital. The study was based upon the cystoscopic and cystometric findings of the post-partum patient. A report of these findings was made in the *American Journal of Obstetrics and Gynecology*, 1941.

Certain questions were raised at that time for further investigation. Some of these have been answered, and additional information has been secured. It is in the interest of the continuation of the study of this phase of Obstetrics and Urology that the paper will be presented.

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Second Meeting

Wednesday, May 8, 9:00 a.m.

Meeting Room: Conference Room No. 9, on Mezzanine Floor, off North Galeria

Paper No. 144:

The Use of Penicillin in Non-Gonococcal Infections of the Urogenital Tract—Henry M. Weyrauch, M.D., 384 Post Street, San Francisco.

The value of penicillin in gonococcal infections has been well established. Obscurities still exist as concerns use of drug in non-gonococcal infections of the urogenital tract. Discussion of lesions susceptible to penicillin. Outline of principles of treatment on basis of type of infection and part involved, infecting organism and effective dosage.

Discussion by Carl E. Burkland, M.D., Sacramento, and Robert Burns, M.D., Woodland.

Paper No. 145:

Ureteral Reflux—James Steinberg, M.D., 1052 West Sixth Street, Los Angeles.

Congenital bladder neck obstruction in 14-year-old girl with history of recurrent unexplained attacks of high fever since birth resulting laterly in syndrome of acute appendicitis which postoperatively proved to be due to right ureteral reflux with chronic cystoscopic and x-ray changes later cured by resection of 4 grams of tissue from bladder neck.

Discussion by A. J. Scholl, M.D., Los Angeles, and James L. Bray, M.D., Los Angeles.

Paper No. 146:

Treatment of Fibrosis of the Corpora Cavernosa—Clyde W. Collings, M.D., 1930 Wilshire Boulevard, Los Angeles.

The fibrous masses largely disappear in twelve to eighteen months. Curvature of penis and painful erections relieved. Satisfactory coitus is restored. Report of five cases. Three of these patients are well five years after receiving treatment, the other two are greatly improved for a lesser period.

Discussion by Miley B. Wesson, M.D., San Francisco, and Cornelius O. Bailey, M.D., Los Angeles.

Paper No. 147:

Excretory Cystograms After Voiding—James R. Dillon, M.D., 490 Post Street, San Francisco.

As a part of excretory urography, valuable diagnostic information on bladder conditions are obtained following the standing films by a cystogram after voiding, in both male and female. Lantern slides illustrating diagnostic points in bladder and lower ureters, with brief case reports.

Discussion by Albert M. Meads, M.D., Oakland, and Milo Ellik, M.D., Long Beach.

Paper No. 148:

Diverticulum of Anterior Urethra: Report of an Acquired Type—Harry A. Zide, M.D., 1911¼ Wilshire Boulevard, Los Angeles.

An acquired diverticulum of the anterior urethra in a 31-year-old male soldier is reported. Only 19 cases have been recorded from 1900 to 1942. The case is discussed from various aspects and lantern slides taken pre and postoperatively will be shown.

Discussion by Dudley P. Fagerstrom, M.D., San Jose, and Ernest E. Kessler, M.D., Los Angeles.

Paper No. 149:

Treatment of Bladder Tumors—Roger W. Barnes, M.D., Russell T. Bergman, M.D., and Carlos L. Turner, M.D., 1216 Wilshire Boulevard, Los Angeles.

A statistical summary of the results of different types treatment of 450 cases of bladder tumors is given. Those treated with radon emanation seeds following both open and closed resection and fulguration of the tumor are compared with those cases which have had no irradiation.

Discussion by Hermon C. Bumpus, M.D., Pasadena, and Gilbert J. Thomas, M.D., Beverly Hills.

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Third Meeting

Thursday, May 9, 9:00 a.m.

Meeting Room: Conference Room No. 4, on Mezzanine Floor, off North Galeria

Paper No. 150:

Chairman's Address—Protein Requirements in the Aged Surgical Patient—Dudley P. Fagerstrom, M.D., 710 Medico-Dental Building, San Jose.

A general discussion of protein needs, incidence of deficiency and the value of corrective therapy, as applied particularly to patients undergoing prostatic surgery.

Paper No. 151:

Perineal Testicle—Arthur B. Cecil, M.D., 1136 West Sixth Street, Los Angeles.

A case of perineal testicle is presented. Ectopia of the testicle is discussed. Normal and abnormal migration. Clinical picture. Incidence. Historical review. Treatment.

Discussion by Donald A. Charnock, M.D., Los Angeles, and B. Harry Hager, M.D., Los Angeles.

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Business Recess

Business Meeting and Election of Officers

Paper No. 152:

What Part Do the Hypogastric Vessels Play in Ischemia and Stasis of the Pelvic Organs?—Francis H. Redewill, M.D., 526-536 Flood Building, San Francisco.

The largest branches of hypogastric artery are compressed hours each day by sitting posture. Continuous stasis of uterus and ovaries or prostate and seminal vesicles over periods of many years of occupational recumbency provoke frigidity, disrupted cycles, low back pain, neurasthenia manifestations and hosts of other symptoms.

Discussion by Tom Schulte, M.D., San Francisco, and James Earl Potter, M.D., Palm Springs.

Paper No. 153:

Simplified Prostatic Surgery—Wilson Stegeman, M.D., 534 B Street, Santa Rosa.

The procedure of prostatectomy, with all its ramifications of long preoperative care, complicated operations, long hospitalization, and long postoperative office care could profitably be simplified, for all concerned. Possibly some of our usually complicated methods could be shortened or simplified without sacrificing anything that increases the safety of the patient.

Discussion by Arno G. Folte, M.D., San Francisco, and Carl Rusche, M.D., Hollywood.

Paper No. 154:

Clinical Evaluation of Urologic Problems in 200 Infants and Children—Walter Pritchard, M.D., 575 Fifth Street, San Bernardino.

A review of experience extending over twenty-five years, chiefly within last five years, in urologic problems of infants and children. Incidence of common lesions, suitability of techniques of investigation, results of treatment; and etiologic hypotheses are discussed. Typical case reports to show need of more interest in children's urology.

Discussion by Arthur Varden, M.D., San Bernardino, and Ivan Finkelberg, M.D., San Bernardino.

XIII

PUBLIC HEALTH SECTION

George M. Uhl, M.D., *Chairman*
116 Temple Street, Los Angeles

Dwight M. Bissell, M.D., *Vice-Chairman*
City Hall, San Jose

John J. Sippy, M.D., *Secretary*
130 South American Street, Stockton

Section Aides:

Meeting Room: Conference Room No. 8, on Mezzanine Floor, off North Galeria

First Meeting

Wednesday, May 8, 9:00 a.m.

Paper No. 155:

Chairman's Address—Does the Public Want Health? —George M. Uhl, M.D., 116 Temple Street, Los Angeles.

There is much public discussion and clamor in the public press regarding the need for improvement in our existant public health and medical care programs. An analysis of these demands reveals that they are prompted more by the desire for prepayment of medical care than for an actual improvement of the public health, and that there is not full acceptance of public health facilities that are now available.

Suggested procedures for rectifying this condition will be discussed.

Paper No. 156:

Public Health Laboratories in California and Their Service to Physicians—Malcolm H. Merrill, M.D., Chief Division of Laboratories, and Deputy Director, California State Department of Public Health, Berkeley.

The State Laboratory and thirty local public health laboratories comprise a closely coöperating organization designed to assist California physicians in the diagnosis of communicable diseases. How this organization functions and the services provided will be described. Specialized diagnostic services offered by the State Laboratory, particularly in the virus field will be noted.

Discussion by H. C. Pulley, M.D., Los Angeles.

Paper No. 157:

Trends in Age Distribution of Childhood Diseases—Elmer M. Bingham, M.D., M.P.H., 130 South American Street, Stockton.

The reported incidence of acute communicable diseases in San Joaquin County is analyzed by five-year periods for 1925-1944, inclusive. During this period, certain diseases have shown a change in age distribution. Diphtheria, poliomyelitis, mumps, and German measles show or suggest a shift to older age groups. Measles, whooping cough, and chickenpox show a shift to younger age groups, in part explained by the local increased birth rate.

Discussion by H. O. Swartout, M.D., D.P.H., Los Angeles.

Paper No. 158:

The Present and Future Advances of Psychiatry in Public Health—Portia Bell Hume, M.D., Director of the Out-Patient Department, The Langley Porter Clinic, San Francisco.

General Plans for preventive psychiatry in California call for:

a. Education of Communities and the medical profession in mental health;

b. Training of psychiatric nurses, social workers, clinical psychologists, occupational therapists, and psychiatrists;

c. Establishment of out-patient clinics for child guidance and for early recognition of mental symptoms;

d. Coördination of the work in existing mental hospitals with education, training and research programs.

Discussion by Lawrence Kolb, M.D., Sacramento.

Second Meeting

Meeting Room: Conference Room No. 1, on Mezzanine Floor, off North Galeria

Thursday, May 9, 9:00 a.m.

Joint Meeting with Section on Dermatology and Syphilology

Symposium on Syphilis

(Round Table Discussion)

(See Papers 96-101)

Third Meeting

Meeting Room: Conference Room No. 2, on Mezzanine Floor, off North Galeria

Thursday, May 9, 1:30 p.m.

Joint Meeting with Section on Dermatology and Syphilology

Symposium on Untoward Effects of Atabrine

(See Papers 102-105)

Friday, May 10, 9:00 a.m.

Fourth Meeting

Meeting Room: Conference Room No. 2, on Mezzanine Floor, off North Galeria

Paper No. 159:

Practical Application of Newer Methods in Control of Rodent and Insect Pests—Harold Farnsworth Gray, M.S., Gr. P.H., School of Public Health, University of California, Berkeley. (By invitation.)

There are two new and very potent rodenticides: "Antu," an alpha naphthyl thiourea, and "1080," or sodium fluoroacetate. The new insecticide "DDT" is proving to be successful against fleas, lice, bed bugs, flies, and mosquitoes when correctly applied under appropriate conditions. Two other insecticides of promise are being tested.

Discussion by John C. Dement, M.D., San Francisco.

Paper No. 160:

The Management of the Potential Rheumatic Child—Helen M. Johnson, M.D., Medical Director, Rheumatic Fever Program, State Department of Public Health, San Francisco.

Diagnosis and management of sub-clinical or potential rheumatic fever is a challenge to every clinician. There is no specific test for rheumatic fever. The classical signs and symptoms which make the diagnosis of the full-blown rheumatic clear-cut are absent or minimal in the potential rheumatics, who, nevertheless, may develop heart damage. In a five-year demonstration program, it has been shown that it is necessary to treat a potential rheumatic fever patient as a rheumatic until proven otherwise. By no other approach can rheumatic fever cease to be the third cause of death in this state.

Discussion by Louis E. Martin, M.D., Los Angeles.

* * *

Business Recess

Business Meeting and Election of Officers

Paper No. 161:

The California Tuberculosis and Health Association's Contribution to the Health Program of This State—Howard W. Bosworth, M.D., 1301 Chavez Ravine Road, Los Angeles.

This report traces the progress in the control of tuberculosis. The close relationship with C.M.A. in graduate education in tuberculosis, heart disease and public health, the medical coördination and direction of policy and the use for which money is budgeted and spent are explained. Future objectives and means of coöperation between practitioners, public health workers and the Association are discussed.

Discussion by Dwight H. Murray, M.D., Napa.

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Agostino Bassi (1773-1856).—A roster of the pioneers in the field of bacteriology would be incomplete without the name of Agostino Bassi. It was he who first showed that silkworm disease is caused by a micro-organism. He was thus a forerunner of Pasteur. The discovery not only led him to conjecture that many diseases were caused by animal or vegetable parasites, but it influenced the scientific thinking of those who came after him—for instance, Schönlein and Henle.—Warner's *Calendar of Medical History.*

OTHER MEETINGS†

CANCER COMMISSION MEETINGS

CANCER COMMISSION

Lyell C. Kinney (Chairman)	San Diego	1946
Harold Brunn	San Francisco	1946
Orville S. Meland (Sec'y, So. Calif.)	Los Angeles	1946
George Sharp	Pasadena	1947
Whitfield Crane (Vice-Chairmn)	Oakland	1947
Gertrude Moore	Oakland	1947
Henry J. Ullmann	Santa Barbara	1948
David A. Wood (Sec'y, No. Calif.)	San Francisco	1948
James F. Rinehart	San Francisco	1948

Microscopic Tumor Conference

Monday, May 6th, in afternoon

Room 359, Science Building, University of Southern California.

Committee: Paul H. Guttman, Chairman, Sutter Hospital, Sacramento.

John W. Budd, Los Angeles.

David A. Wood, San Francisco.

A. G. Foord, Pasadena.

Reservations for the conference and arrangements for presenting slides at the conference are to be made with Dr. Guttman.

Radiological Conference

Monday, May 6th, 9:30-11:30 a.m.
2:00-5:00 p.m.

Auditorium, California Hospital, 1414 S. Hope Street.

Committee: L. H. Garland, Chairman, San Francisco.

Local Arrangements Committee:

Donald Laing, Chairman, Pasadena.

Wybren Hiemstra, Los Angeles.

Joseph Jellen, Los Angeles.

Conference will consist of diagnostic problems with the presentation of proven cases. There is also to be a symposium on problems in therapeutic radiology.

Reservations may be made with Dr. Laing.

* * *

Monday, May 6, 9:30 a.m. to 11:30 a.m. and 2:00 p.m. to 5:00 p.m.

The annual Radiological Conference of the Cancer Commission will be held on Monday, May 6, 1946, at Los Angeles (Auditorium of the California Hospital, 1414 South Hope Street). The morning session will be from 9:30 to 11:30 and will be devoted to diagnostic problems. The afternoon session will be from 2:00 to 5:00 and devoted largely to therapeutic problems.

Members wishing to present a diagnostic or therapeutic case problem are asked to prepare the material so that it can be distributed amongst the members attending the conference. For example, with a diagnostic problem, positive prints of roentgenograms, sufficient for six separate illuminators are desirable. It is, of course, essential that all cases be pathologically verified.

Please make reservations with Dr. L. H. Garland, Chairman, 450 Sutter, San Francisco 8, California.

Cancer Commission Conference

Thursday, May 9th, 6:30 p.m.

Biltmore Hotel

This will be a dinner meeting with the Commission for members of the Cancer Committees of the County Medical Societies and representatives of approved Cancer Clinics. This will be a round table discussion of problems in cancer control as they appear in the County Medical Society and Cancer Clinics. (See bulletin board.)

Cancer Commission of C.M.A.

Dinner Meeting, Thursday, May 9, 1946

(Probably in Conference Room 8)

A Joint Conference of C.M.A. Cancer Commission and Cancer Committees of the County Medical Societies and Representatives of Approved Cancer Clinics.

Program

Dr. Whitfield Crane, Vice-Chairman, Cancer Commission, presiding.

Dr. Philip K. Gilman, President, C.M.A., Chairman of the Council.

Dr. S. J. McClendon, President-Elect, C.M.A., Member California State Board of Health.

Dr. W. L. Halverson, California Director of Public Health,—"Cancer Control in California."

Mrs. Doris Ryer Nixon, State Commander, Field Army, American Cancer Society,—"Program of the Field Army."

Dr. George Pack, Surgeon, Memorial Hospital, New York,—"Cancer Clinics."

Dr. George Sharp, Chairman, Los Angeles County Cancer Committee,—"Education of the Profession in Cancer."

Dr. Leonard G. Dobson, Chairman, Editorial Committee,—"The Cancer Manual of the C.M.A."

Dr. L. C. Kinney, Chairman, Cancer Commission,—"Prevention Clinics";—"The C.M.A. Program in Cancer Control."

* * *

Round Table Discussion

"Needs and Problems in Cancer Control in the County Medical Society and the Cancer Clinic."

California State Board of Public Health Invites Physicians to Attend Meeting on May 8th

As has been the custom, the State Board of Public Health will hold a regular meeting at the time of, and in conjunction with, the meeting of the California Medical Association in Los Angeles on Wednesday, May 8. The Board holds this meeting at the time of the meeting of the Association in order that it may have the advice, comments, suggestions, and criticisms of any of the members of the profession who are interested in the public health program. For meeting room in Hotel Biltmore, see bulletin board or convention program.

Traditionally the California State Department of Public Health has held the philosophy that the medical profession is the overwhelmingly important factor in the maintenance of the public health, and that the Department, working closely with the local departments and the profession, can act as a catalyzing agent to bring about the better utilization of all the factors and forces available.

The relationships between the organized profession and health departments have not always been entirely amicable, but it is my strong belief that, where relationships have not been sympathetic, the most important reason has been that either the health officer or the county society has stood aloof and has not been willing to sympathetically study the problems and interests of the other.

This May meeting, then, presents an opportunity for continuing the relationship which now exists and presents an opportunity for any members of the profession to indicate problems in local areas which they believe should merit the attention and consideration of the Board.

The time and place of the meeting will be conspicuously posted.

Attention is called also to the meetings and programs of the Section on Public Health. It is hoped not only health officers, but that many physicians in general or special practice will attend the meetings of the C.M.A. Section on Public Health.

Benevolence Fund of the Los Angeles County Physicians' Aid Association

Articles concerning the campaign of the Los Angeles County Physicians' Aid Association to raise a fund of Five Hundred Thousand Dollars ($500,000.00), the proceeds and income of which will be dedicated to aid for needy physicians, have appeared in past issues of the Official Journal.

The Los Angeles County Physicians' Aid Association is a nonprofit organization incorporated in 1940. At the present time it is giving aid to some 68 physicians or their dependents.

Through past campaigns, the Los Angeles County Physicians' Aid Association has raised the sum of One Hundred Seventy-eight Thousand Dollars ($178,000.00) to aid in the work.

The Governing Board has plans to purchase a large acreage on which will be built a country house for dependent doctors, their wives and children. Bungalows with central building for dining, library and entertainment, have received tentative blueprints. These plans are not definite, and it is possible that the money available will be used to create a fund from which cash payments will be made to those who are in need rather than furnishing domiciliary care. Possibly a combination of the two plans will be found most practicable.

The Board of Directors of the Los Angeles County Physicians' Aid Association, which has offices at 1925 Wilshire Boulevard, Los Angeles 5, contains the names of many prominent members of the Los Angeles County Medical Association.

At the meeting of the California Medical Association, to be held in Los Angeles May 7-10, plans are being made for a publicity campaign to promote the objectives of the organization. At that meeting there will be an attractive prize. The attention of those who will be in attendance at the annual session of the California Medical Association is called thereto.

Medical Veterans' Association of Los Angeles County

Medical Veterans' Association of Los Angeles County calls attention to a meeting to be held in the Auditorium of the Los Angeles County Medical Association, located at 1925 Wilshire Boulevard.

The meeting will be held as called on Tuesday evening, May 7th, at 8:00 o'clock. The telephone number of the Los Angeles County Medical Association is DRexel 7175.

All physicians who are medical veterans are cordially invited to attend this meeting.

For additional information concerning the Medical Veterans' Association of Los Angeles County, and its objectives see in current issue on page 264.

Medical Society of the State of California

An optional Medical Defense organization, founded in 1923, composed of C.M.A. members, having as an objective the promotion of a group effort to study, combat and partially eliminate the possibilities of malpractice litigation, and to support colleagues who are unjustly sued.

For time and place of meeting, see bulletin board.

MRS. R. B. EUSDEN
President, Woman's Auxiliary to the
California Medical Association
1946

MRS. LAWRENCE K. GUNDRUM
Recording Secretary, Woman's Auxiliary to the
California Medical Association
1946

V

WOMAN'S AUXILIARY

Sixteenth Annual Session

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

Headquarters at Biltmore Hotel, Los Angeles

Mrs. Ralph Eusden, *President*

Mrs. Ludwig L. Kaftan, *Convention Chairman*

Tuesday, May 7

9:00 a.m.-5:00 p.m.—Registration.

9:30 a.m.—Opening Session of the California Medical Association (Ball Room). All Auxiliary members and doctors' wives are invited to attend.

10:00 a.m.—Pre-Convention Board meeting, Suite 3333-3334, Biltmore Hotel.

Wednesday, May 8

8:00 a.m.-12:00 noon—Registration.

9:30 a.m.—First general session of the Sixteenth Annual Convention, Suite 3333-3334 Biltmore Hotel, Mrs. Ralph Eusden, presiding.

1:00 p.m.—Luncheon—Honoring: Mrs. Ralph Eusden and Members of the State Advisory Board, Mrs. C. C. Landis, presiding.

Thursday, May 9

8:00 a.m.-12:00 noon—Registration.

9:30 a.m.—Second General Session of the Sixteenth Annual Convention—Suite 3333-3334 Biltmore Hotel, Mrs. Ralph Eusden, presiding.

1:00 p.m.—Luncheon—Honoring: Mrs. Philip K. Gilman, wife of the President of the California Medical Association, and Past State Presidents.

Friday, May 10

Post-Convention Board meeting.

Executive Board and State Advisory Board meeting.

HOTELS

Headquarters Hotel—75th Annual Session California Medical Association
Hotel Biltmore, 515 South Olive, Los Angeles, 13
(Telephone MIchigan 1011)

The official headquarters of the next annual session of the California Medical Association to be held at Los Angeles, Tuesday, May 7 through Friday noon, May 10, 1946, will be the *Hotel Biltmore*, 515 South Olive Street (Olive, between Fifth and Sixth Streets), Los Angeles. Because of postwar conditions and prospective attendance, the facilities of other hotels must also be used.

All requests for reservations must be sent to the hotels direct. In writing, it is well to state the number in the party, date of arrival, date of departure, nature of accommodations desired (single room, double room, double bed, twin beds, bath).

Los Angeles Hotels: With Telephone Numbers

A list of some hotels in Los Angeles within easy distance of the Hotel Biltmore follows:

Hotels	*Telephones*
Alexandria Hotel, 210 W. Fifth St.	(MAdison 2741)
Ambassador Hotel, 3400 Wilshire Blvd.	(DRexel 7011)
Biltmore Hotel, 515 S. Olive	(MIchigan 1011)
Carlton Hotel, 519 S. Figueroa St.	(MIchigan 6571)
Chapman Park Hotel, 516 S. Alexandria Ave.	(FI 1181)
Clark Hotel, 426 S. Hill St.	(MIchigan 4121)
Gates Hotel, 831 W. Sixth St.	(TRinity 3931)
Hayward Hotel, 206 W. Sixth St.	(MIchigan 5151)
Mayfair Hotel, 1256 W. Seventh St.	(FItzroy 4161)
Mayflower Hotel, 535 S. Grand Ave.	(MIchigan 1331)
San Carlos Hotel, 507 W. Fifth St.	(MUtual 2291)
Savoy Hotel, 601 W. Sixth St.	(MAdison 1411)
Stillwell Hotel, 838 S. Grand Ave.	(TRinity 1151)
Town House, 639 S. Commonwealth Ave.	(EX 1234)
William Penn Hotel, 2208 W. Eighth St.	(EX 3181)

VI

TRANSPORTATION INFORMATION

Reduced-rate convention transportation is *not* available this year.

Members are urged to make their transportation reservations at the earliest possible date in order to secure reservations on the overtaxed travel lines.

VII

ENTERTAINMENT

Consult bulletin board in Main North-South (Fifth Street to Ramp) galeria for information concerning alumni and similar luncheons or dinners.

President's Dinner.—Hotel Biltmore, Wednesday, May 8, at 7:30 p.m. in Biltmore Bowl (entrance by way of South Galeria, near ramp). Reservations must be made in advance, as capacity of dining room is limited. Reservations can be made for single tickets and for tables of eight or more persons. Make reservations at Registration Desk. Such reservations should be in charge of only one person, in order to avoid confusion for the hotel management. All who are at a "table to be reserved" should let their spokesman order for them. "Reserved Tables" must not be encroached upon.

The Local Committee on Arrangements will present at the Dinner to the President, an entertainment program at 9:30 p.m. sharp. During the floor show the dining room doors will be closed and table service will stop. For these reasons it is imperative that those attending the dinner should be in the dining room promptly at 8:00 p.m.

Dancing (in the Biltmore Bowl) to Hotel Biltmore's orchestra will follow the Dinner to the President.

LOS ANGELES

Some Highlights in Its History

Los Angeles is the second oldest city officially founded in California and the third oldest in rank as an early habitation center. San Diego Mission, founded in 1769, was the earliest civilized development in California. From San Diego, Gaspar de Portola and Juan Crespi marched north and began developments in the Monterey area in 1770. San Gabriel Mission, near Pasadena, was founded September 8, 1771. Just ten years later on September 4, 1781, *"El Pueblo de Nuestra Senora la Reina de Los Angeles de Porciuncula"* (now Los Angeles) was officially founded by the third Spanish Governor to California, Felipe de Neve.

Before the founding of Los Angeles, about 300 Indians, called Yang-na, lived in the Los Angeles area, unmolested and unmindful of their inevitable doom.

During many years following the founding of Los Angeles nothing of note happened. The country was left to the explorers and that arduous colonizer, the missionary.

All life in the Pacific Southwest in those days revolved about the missions, which was primarily communal among the Indians, who were disciplined by soldier guards. Agriculture and livestock were the principal industries. Commerce, as it is known today, was unknown. Lethargy, indifference and stagnation, from a world point of view, were the order of the day in the early Spanish era of Los Angeles.

In 1822, news arrived from Mexico that these onetime Spanish colonies were free and independent. How-

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VIII

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CALIFORNIA MEDICAL ASSOCIATION

REPORTS OF GENERAL OFFICERS, C.M.A. COMMITTEES AND
COMPONENT COUNTY MEDICAL SOCIETIES
For Calendar Year, 1946
(For Index of Reports, See Page 231)

Foreword.—The official reports which follow will be presented at the coming session of the House of Delegates.

Delegates, therefore, are urged to familiarize themselves with their contents.

Members, likewise, are requested to become familiar with the recommendations in these reports, and to discuss them with other members and delegates.

Through such coöperation, action that will be in line with majority opinion, is more apt to be taken.

* * *

I

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the House of Delegates:

This past year has seen the spread of the threat to the private practice of medicine from certain states, including California, to nation-wide scope backed by the highest authority—the President.

Here in California there exists a temporary lull pending reports from Interim Committees of the Legislature at present studying the necessity for compulsory insurance.

Until now the efforts of your elected representatives have met with success. This has been made possible only by the practically unanimous support accorded those officers by the membership at large. Not only will and must this support continue but it should be ever more vigorous, more vocal and whole-hearted if we are to continue to have a voice in how our profession shall be perpetuated.

Respectfully submitted,
P. K. Gilman, *President.*

REPORT OF THE PRESIDENT-ELECT

To the President and the House of Delegates:

During the past year I have attended all the regular and special meetings of the Council and the Executive Committee and have visited most of the component societies in the southern part of the State.

Respectfully submitted,
S. J. McClendon, *President-Elect.*

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

Last year at this time we were at war. We were at war as a nation, fighting for our very life and the ideals that make the living of life worthwhile. The medical profession was at war also, fighting ideas of political economy that might destroy those factors of the practice of medicine which we believe essential.

In my report to last year's House of Delegates I said as follows—"our House of Delegates must lay careful grounds for our policies of the future. Our soldier confreres must come home to us with a knowledge that we have planned for the future, theirs and ours. We must preserve for them the things that they cherish here at home as they are fighting there to preserve things that we cherish."

This year our national war has been won. As a profession, however, we still stand in battle. We at home have held open the choice as to what political economy shall prevail in the practice of medicine. Our fight has been hard. Now we welcome home our veteran confreres. We want to report to them the home events that occurred while they were away. We expect them to take up again with us the crusade to preserve those things which we cherish, to enrich our vision by their experience and to make such changes as may be necessary to meet the medical needs of the people.

I ask that every member of the California Medical Association discuss his problems with the Delegates and attend all meetings to the end that we may have a profession alert in mind, eager in spirit and united in purpose.

Respectfully submitted,
E. Vincent Askey, *Speaker.*

REPORT OF THE VICE-SPEAKER

To the President and the House of Delegates:

Hot packs and massage of the abdomen for the pain of acute appendicitis, morphine for strangulation of the small bowel, and aspirin to combat lobar pneumonia are not treatments which would stand up under the acid test of malpractice defense. Constant relentless competition in the open and free market of ideas quickly discards dangerous and useless forms of therapy and is ever developing new and more effective means of preventing and combating disease and relieving suffering. Medical Science as yet in America has placed no ceilings over ability and no floors under mediocrity. Results speak for themselves.

Our abandonment of the economic free market as a war measure may have seemed superficially plausible. Our failure to return to the free market—which is the most important single factor accounting for America's preëminence in the production and widespread consumption of goods and services—indicates an economic illiteracy just as heinous as the ignorance of the practitioner who poultices and massages the acutely inflamed appendix instead of removing it. Just as a basic knowledge of anatomy, physiology and pathology is essential to effective therapeutics, so is a basic understanding of economic principles requisite to any satisfactory treatment of disease in the body politic.

Price controls of all kinds, interference with the free flow of goods and services, restrictions on acreage, slaughter of little pigs, featherbedding and stand-by practices as well as dumping and Cartel manipulations all proceed from the quaint economic fallacy that somehow by destroying part of that which we have and making it difficult if not impossible to produce more, we shall all have a greater supply of goods and services to enjoy. To the intelligent, well-informed medical man, these pseudo-economic practices which have been sold to our public by the sooth-sayers in high places are just as reprehensible as the treatment of human disease based upon ignorance and superstition. Unfortunately, to date there is no way to press a charge of malpractice against the economic quack.

The attack on Organized Medicine is just one phase of cultist pseudo-economics. The remedy is widespread dissemination of basic information. The law of supply and demand has not been repealed, the law of diminishing returns has not been altered, and Gresham's Law, that bad money drives out good money, is still operative in spite of our managed currency and our store of gold bullion in a hole at Fort Knox, Kentucky.

Your State Association long ago took the lead in organizing means for the prepayment of the costs of illness. It is now planning a Statewide campaign of public information relative to what constitutes good medical care, how that care is developed, and how it may best be obtained with a maximum return for the money so expended.

As a part of this campaign in public education, it would seem quite appropriate to devote considerable space and time to emphasis upon economic principles in general, as well as their application to the distribution of efficient medical care.

Respectfully submitted,
L. A. Alesen, *Vice-Speaker.*

REPORT OF THE CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

It has been my privilege and duty to preside at the meetings of the Council during 1945. This year has been marked by many challenging situations. These have required deep and serious consideration on the part of your officers. These officers have given freely of their time, have coöperated perfectly and have established a record for pulling together in order to best serve the interests of the California Medical Association in an admirable and unselfish manner.

Respectfully submitted,
P. K. Gilman, *Chairman of the Council.*

REPORT OF THE COUNCIL

To the President and the House of Delegates:

1. Meetings.

During the year 1945 the Council of the California Medical Association held 7 meetings, the same being 322 to 329, inclusive, as of the following dates: January 4-5-6; February 25; May 5; May 6; May 7; August 12; and October 21.

The proceedings of the various meetings were printed in California and Western Medicine in the following issues: April, page 179; May, page 258; June, pages 344-358; October, page 175; December, page 277.

2. Membership.

On January 1, 1945, the California Medical Association was credited with a membership of 7,627 doctors of medicine (civilian members, 5,453; military members, 2,174). On December 31, 1945, the total membership was 7,911; an increase of 284 members for the calendar year 1945 (civilian members, 6,122; military members, 1,789). The total number of members who died during the year was 91.

3. California Physicians' Service.

California Physicians' Service, now in its seventh year, was brought into existence by the California Medical Association in an effort to make medical service of proper quality, more available to citizens belonging to the lower income brackets.

C.P.S. is a separate non-profit corporation and its constituted governing group (Administrative Members) will hold a meeting in Los Angeles on Thursday afternoon, May 9, to elect officers of the corporation and to transact indicated business.

Your Council, in calling attention to the May 9th meeting of Administrative Members, would make brief informative comment on some C.P.S. activities of the last year:

(a) California Medical Association supplied funds to C.P.S. to make possible better provision for adequate medical care in the housing project at Richmond in the San Francisco East Bay area.

(b) C.M.A. supplied funds to carry on an educational campaign in professional and service clubs, in efforts to secure wholehearted support in attainment of C.P.S. objectives.

(c) California Medical Association used its good services in an endeavor to promote procedures whereby C.P.S., the three Blue Cross Hospitalization groups (H.S.C., H.S.S.C., and Intercoast), working in harmony with one another and with the California Medical Association and Association of California Hospitals, would all share in increased growth and capacity for service.

(d) Your Council is particularly gratified with the utilization of C.P.S. as a constituted state agency, through which the federal Veterans' Administration is now in position to provide medical care to veterans of recent wars.

(e) California Medical Association notes with pleasure the action of constituted authorities of the American Medical Association in, at long last, making specific recommendations concerning prepayment sickness insurance plans.

(f) The above and other matters, such as fee-for-service and indemnity plans, having relation to C.P.S. functions and growth will be presented to the Administrative Members of C.P.S. and are here only mentioned to permit C.M.A. members to know that organized medicine, as represented by California Medical Association, has endeavored to do all within its power to show the value of voluntary prepayment sickness insurance plans and policies.

4. Compulsory Health Insurance Bills of the 1945 California Legislature.

In January, 1945, the Council deemed it expedient to issue a call for a special session of the C.M.A. House of Delegates, and at that time, prospective compulsory health insurance bills about to be presented to the Legislature were considered.

Acting under instructions from the House of Delegates, your Council used all legitimate measures to prevent passage of the bills concerned. The story of the Sacramento battles has appeared in the Official Journal. It is gratifying to know that the powerful groups who sought to inflict a compulsory health insurance system on the people of California were defeated.

The former or related measures may appear in the legislative chambers when the California Legislature convenes in January, 1947, for its regular (the 57th) biennial session, since the last Legislature appointed interim committees to bring in reports and recommendations.

Since public welfare interests are intimately involved in compulsory health insurance systems, it behooves all members of the California Medical Association to give support to only those legislative candidates who have been on record in support of sound public health laws.

5. Unemployment Insurance Funds.

One of the controversial measures enacted at this year's special session of the California Legislature was a disability insurance bill, through which citizens engaged in industrial work will draw compensation from the Unemployment Insurance Fund (when unemployment is due to illness).

It will be of interest to watch how this law works out in actual practice.

6. Appropriations for Medical Schools of the University of California.

Reference is here made to the establishment of a new medical school as a department of the University of California at Los Angeles. An initial appropriation enacted at the 1946 special session of the California Legislature in amount of seven million dollars, was signed by Governor Earl Warren.

Also, an appropriation of four million was granted at the special session, to aid in erection of needed buildings at the San Francisco Medical Center of the University of California. For this institution, other State funds in amount of some two million dollars will make possible erection of structures to a total cost of some six million dollars.

The Council expresses its approval of these actions by the State of California, in thus providing funds that will make possible an extension of high quality medical teaching for California.

These appropriations will permit the four existing schools and the one new medical college in California to move forward in better attainment of their mutual objectives.

7. Procurement and Assignment Service — Postwar Committee.

The services rendered during and after the war years by the California Procurement and Assignment Service for Physicians were most valuable, not only in making it possible for California to supply its quota of well trained physicians and surgeons for the medical departments of Army and Navy, but also in maintaining morale and adequate medical service for civilians.

The thanks of the Association may well be extended by the House of Delegates to the State and County P. & A. Committees. Their work was well done.

The special Postwar Committee will submit to the House of Delegates recommendations on existing and possible future needs.

8. Advisory Planning Committee.

C.M.A. members who scan the minutes of Council meetings have noted the desirable recommendations that have been made by the Advisory Planning Committee. Some of the recommendations will probably receive comment by the reference committees of the House of Delegates, since it is desirable, on matters of important policy, that not only the Council, but also the House of Delegates should be on record.

In this connection, mention may be made of the request by some of the larger component county units of the C.M.A. that they be aided through State Association subsidies that would permit them to employ full-time executive secretaries to better carry on their organization and other work.

9. American Medical Association Will Meet in San Francisco July 1-5, 1946.

The American Medical Association will again hold an annual session in California, the San Francisco County Medical Society to act as host to the visiting delegates and physicians.

All members of the California Medical Association who can attend the A.M.A. session should plan accordingly.

10. Woman's Auxiliary to the California Medical Association.

Appreciation is expressed to the members of the Woman's Auxiliary to the California Medical Association for the important services rendered by them. The State and County Auxiliaries are valuable aids to organized and scientific medicine.

Arrangements have been made to permit the publication of what could be called a house bulletin—"The Courier," and through it, it is hoped to bring to the State and County Auxiliaries, not only an increasing number of interested and working affiliates, but to keep all Auxiliary members in close touch with public health and medical activities of their respective communities.

11. A History of the California Medical Association —Appointment of Retiring Secretary-Editor as Honorary Historian.

Under the name "Medical Society of the State of California," the California Medical Association was founded in year 1856, some ninety years ago.

No history of the Association—now grown to be third largest constituent state medical society in the Nation—has ever been written. Regretfully, it must also be acknowledged that the C.M.A. possesses practically no historical records.

Therefore, compilations for a History of the California Medical Association will require much painstaking and time-consuming reading and research of source material available only in the publications to be found in public and private libraries.

After many years of service as a C.M.A. officer, Doctor George H. Kress, now having reached the age of 70 and over, will retire as Association Secretary and Editor of CALIFORNIA AND WESTERN MEDICINE.

Your Council, having in mind Doctor Kress' interest and knowledge of the California Medical Association, at its 330th meeting on February 1, 1946, adopted the following:

"(a) A History of the California Medical Association. —Reference was made to the desirability of compiling a history of the California Medical Association, now in its 75th year, the subject having been considered at the 328th and 329th Council meetings. (CALIFORNIA AND WESTERN MEDICINE, October, 1945, Item 20(e), page 180, and December, 1945, Item 24, page 282.)

"After discussion, on motion made and seconded, the following resolution was adopted:

"Resolved, That the position of Honorary Historian of the California Medical Association is hereby created, said position to be entirely honorary and without compensation; and be it

"Further Resolved, That the retiring Secretary-Editor, Doctor George H. Kress, be appointed as Honorary Historian, he to act in that capacity until such time as other action is taken."

The Council trusts the House of Delegates will approve the plan to proceed with the compilation of a History of the California Medical Association, to be carried on by the Honorary Historian, in conjunction with the standing C.M.A. Committee on History.

12. Survey of California Hospitals.

Medical care during recent years has more and more implied utilization of hospital facilities. Increasingly important, therefore, is the need of maintaining high standards in hospital buildings, equipment, personnel and procedures. Also, to make available to all citizens, adequate hospital facilities.

The Council asks the coöperation of all concerned in the survey of California Hospitals now being carried on through the State Department of Public Health.

Your Council Chairman has been placed in charge of the survey study.

13. Retirement of Doctor George H. Kress as Association Secretary and Editor of "California and Western Medicine."

Note has been made above that Doctor George H. Kress, having reached retirement age, will lay down his duties as Association Secretary and Editor of CALIFORNIA AND WESTERN MEDICINE at the close of the present annual session.

In other reports, mention is made of the many years of service rendered by Doctor Kress, in various official positions of the California Medical Association.

The Council proposes to the House of Delegates that it would be a fitting tribute to Doctor Kress, in appreciation of services rendered over some four decades, that he be given a life pension for his remaining years.

The Council at its meeting on February 1, 1946, took formal action as indicated below, and submits the same to the House of Delegates for approval:

"Retirement of Doctor George H. Kress as Secretary-Editor.—Doctor George H. Kress having reached retirement age, and the Council having considered the subject at the 328th meeting on August 21, 1945 (October California and Western Medicine, Item 20, Page 180) and at the 329th meeting on October 21, 1945, discussion followed on what would be proper recognition of services rendered over many years by Dr. Kress.

"After discussion, and on motion duly made, seconded, and carried, the following resolution was adopted:

"*Resolved*, That the Council include in its annual report to the House of Delegates at the May, 1946, session, a recommendation that Doctor George H. Kress, presently the Secretary and Editor of the Association, be granted retirement status and that in recognition of his many years of continuous devoted service to the welfare of the Association, Doctor Kress be granted a pension for life, commencing at the end of the 1946 annual session, payable at the rate of $315.00 (three hundred and fifteen dollars) per month; provided only, that in any month or months during which Doctor Kress accepts or undertakes any salaried position or positions carrying the aggregate compensation in excess of $15.00 (fifteen dollars) per month, then for such month or months, Doctor Kress shall not receive the monthly pension aforesaid."

14. C.M.A. Cancer Commission.

During the last several years, increasing attention has been given to cancer research clinics and preventive and other educational work. The Council has reactivated the Association's Cancer Commission. As a result, real progress is being made for California in this important medical field.

15. California Industrial Accident Commission.

The surcharge and a revised fee schedule for professional services rendered to citizens working in industry are still a subject for conferences with State and other authorities. The report of the Legal Department of C.M.A. gives further information thereon.

It is to be hoped the legitimate requests of the medical profession for long over-due revision of the schedule of fees will meet with success in the near future.

16. American Red Cross Blood Procurement Facilities.

Report will be made by a Council Committee on procedures to be used in places where blood procurement facilities may be established. It is possible the House of Delegates may wish to make definite recommendations in regard thereto.

17. Affiliated Organizations.

(a) California Medical Association has continued to give financial support to the United Public Health League, which maintains a Washington office, to make available for interested citizens bulletins on public health and related legislation that may be pending in Congress.

(b) C.M.A. has also aligned itself with the organization of state medical society presidents, whose meetings and papers have been valuable aids in the formulation of public relations policies by the American Medical Association.

18. Miscellaneous Items.

Attention is called to minutes of the Council printed in California and Western Medicine for April, 1946, appearing under Item 20(b) on Editorial Policy; Item 20(c) on Proposed Amendment to Constitution; and Item 20(e) on Retirement Plans for Employees.

Reports of Council Committees thereon will be submitted to the proper reference committees of the House of Delegates.

Respectfully submitted,
The Council of the California Medical Association,
Philip K. Gilman, *Chairman*.

REPORT OF THE PRESIDENT OF THE "TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION"

To the President and the House of Delegates:

The Board of Trustees has held regular meetings during the year just elapsed in order to transact the business of the Association properly coming before it. The Board holds in trust the monies and properties of the California Medical Association, and the report of its activities and financial status of the Association is included in the report of the Treasurer.

Respectfully submitted,
P. K. Gilman, *President*.

REPORT OF THE SECRETARY-TREASURER

To the President and the House of Delegates:

In accordance with past custom, your Secretary-Treasurer submits his report under two subheadings: (1) Report of the Association Secretary, and (2) Report of the Treasurer.

I. Report of the Association Secretary

As stated in reports of former years the work of the Association Secretary has to do with his activities for the constituted authorities of the C.M.A., as outlined in the Constitution and By-Laws; namely, as secretary of the following bodies: House of Delegates, Council, Executive Committee, Committee on Scientific Work, (Preparation of Annual Session Scientific and Other Programs), Committee on Postgraduate Activities, Committee on History. In addition there is general correspondence with other state medical societies, and with members of the Association and others.

With the limited amount of clerical help available it has been difficult, at times, to turn out all work promptly. Meetings of the constituted bodies of the Association imply special work, not only in preparation of agenda, but also, on occasion, because of the large amount of follow-up attention needed to carry out instructions concerning actions taken.

Your Association Secretary, having now reached age 71, will retire from his secretarial position at the close of this year's annual session, in May, 1946. In May, 1907, some 39 years ago, your present Association Secretary was elected Councilor for the 2nd District (then Los Angeles, Kern and Ventura counties), and he has had the honor of having been a member of the Council during all these years, either as an elected or ex-officio Councilor. To have had the privilege of active service as a C.M.A. officer for practically four decades has been to him a great pleasure. He has been under heavy obligation to all who during this period aided him in his Association work.

To officers and members with whom in recent years he has had active affiliation, in activities of mutual interest, he also expresses his deep and earnest appreciation. He will treasure the memory of many pleasant associations.

II. Report of the Treasurer

The C.M.A. Constitution provides that the person who is elected to the office of Secretary-Treasurer must hold the degree of Doctor of Medicine. In such capacity the undersigned submits: (a) The Original Budget approved by the House of Delegates (in 1944) to apply to the calendar year 1945; and (b) The Report of the Certified Public Accountants (Messrs. Hood and Strong of San Francisco) on moneys received and expended.

By Council action, the functions concerning the collection and disbursement of funds of the Association have been delegated to the Executive Secretary as one of his responsibilities, and report thereon will be made by Mr. Hunton.

In scanning the report of the Certified Public Accountants, it is important for members to keep in mind that the funds of the California Medical Association are received and spent through two separate organizations, under two separate authorities: (1) Current maintenance and administrative income and expenses, as credited to and charged against the "California Medical Association"; and (2) Reserve funds, held by the "Trustees of the California Medical Association," a nonprofit corporation composed of the year-by-year Councilors, who as a corporation holding company for the California Medical Association, jointly function in compliance with the corporate laws of the State. From time to time, the C.M.A. Council transfers excess or reserve funds to the "Trustees of the California Medical Association." Also, when occasion demands, the California Medical Association borrows from the "Trustees" to cover expenditures of maintenance and special activities, not foreseen at time when the budget for the calendar year was adopted.

The financial records of the Association are on file in the headquarters office, should additional information be desired by any county society or member.

Respectfully submitted,

George H. Kress, *Secretary-Treasurer.*

* * *

CALIFORNIA MEDICAL ASSOCIATION

Budget Income (Estimated) for Year 1945

1. Membership Dues	$ 90,000
2. Advertising Sales	25,000
3. Journal Subscriptions	500
4. Reprint Sales (Net)	100
5. Annual Session	....
6. Miscellaneous (includes earned interest, Herzstein Bequest, etc.)	1,500
Total Revenues (Estimated)	$117,100

Budget Expenditures (Estimated)

7. Rent	3,288
8. Telephone and Telegraph	850
9. Postage	750
10. Stationery and Printing	
11. Office Supplies	2,000
12. Office Expense	
13. Salaries:	
(a) Secretary-Treasurer	4,140
(b) Executive Secretary	9,000
(c) Clerical	9,500
(1) Social Security Tax	200
(2) Unemployment Tax	200
14. Travel Expenses:	
(a) Officers	750
(b) Councilors	3,000
(c) Executive Committee	250
(d) Secretary	750
(e) A.M.A. Delegates	2,500
15. Council-Executive Committee Expense	750
16. Annual Session	6,000
17. Employees' Annuities	500
18. Pensions	960
19. Dept. of Public Relations	1,000
(a) C.P.S. Promotion	....
20. Cancer Commission	1,000
21. Committees' Expenses	1,500
22. Committee on War Effort	2,000
23. Postgraduate Committee	2,000
24. Public Policy and Legislation	13,500
(a) United Public Health League	....
25. Benevolence Committee	5,000
26. Secretarial Conference	1,200
27. Donations to Libraries	2,250
28. Legal Department	5,500
29. Woman's Auxiliary	200
30. Equipment Expense	1,000
31. Miscellaneous	3,000
32. California and Western Medicine:	
(a) Printing	18,000
(b) Postage and Mailing	1,500
(c) Advertising Commissions	5,000
(d) Discount and Collections	300
(e) Editor's Salary	4,600
(f) Supplies	450
(g) Office Postage	750
(h) Illustrations	600
(i) Doubtful Accounts	250
(j) Addressograph Expense	300
(k) Editorial Board Travel	300
Total Expenses	$116,588

* * *

Report of the Certified Public Accountants, Hood and Strong, San Francisco, follows:

Report of Examinations

* * *

I. California Medical Association
and of
II. Trustees of the California Medical Association
(A Corporation)

San Francisco, California

December 31, 1945

I

California Medical Association

HOOD AND STRONG
CERTIFIED PUBLIC ACCOUNTANTS
SAN FRANCISCO

No. 1371-1544 January 21, 1946

California Medical Association.

Dear Sirs:

As per your instructions, and following upon our similar attention for previous years, we have made an examination of the accounts and records of California Medical Association for the year ended December 31, 1945, and present hereinafter the following statements:

California Medical Association and Trustees of the California Medical Association (a Corporation):—
Combined Comparative Balance Sheet — December 31, 1945 and December 31, 1944

* * *

California Medical Association:—
Balance Sheet—December 31, 1945
Statement of Income and Expenditure—Comparative for Years Ended December 31, 1945 and December 31, 1944
Expenditure—Comparative for Years Ended December 31, 1945 and December 31, 1944

We have also made an examination of the accounts of the Trustees of the California Medical Association, a nonprofit corporation, and have rendered a separate report thereon.

The following comments are submitted in amplification of the various items appearing in the statements herein submitted and indicate, generally, the scope of our examination:—

Combined Comparative Balance Sheet—
December 31, 1945 and December 31, 1944

California Medical Association and Trustees of the California Medical Association (a Corporation)

This statement exhibits in condensed form the combined assets and liabilities of both organizations. The assets and liabilities of the California Medical Association will be discussed in detail hereinafter, and a separate report is being presented as to the assets and liabilities of the Trustees of the California Medical Association (a Corporation).

* * *

Balance Sheet—December 31, 1945
California Medical Association
Assets

Cash—$32,292.32:

This consists of the following:

In Banks	$23,068.33
On Hand	9,183.00
Petty Cash Fund	40.99
	$32,292.32

The amount on deposit in banks was verified from the basis of confirmations received by us directly from the depositaries. The amount of cash on hand of $9,183.00, which was verified by us, represents monies received the last few days of December which were deposited in January. The Petty Cash Fund was counted.

Accounts Receivable—$3,480.23:

These consist of "Journal" (California and Western Medicine) advertisers, in amount $3,980.23, less a reserve of $500.00 which has been established in prior years to provide for doubtful accounts. We examined accounts totaling the above sum, but we did not verify the amounts by direct correspondence with the individual debtors. These accounts are considered to be good, and collectible in the ordinary course of business.

* * *

Trust Fund:—$5,808.08:

These consist of (a) the Morris Herzstein Bequest Fund of $3,114.58, and (b) the Benevolence Fund of $2,693.50.

(a) The changes in the Herzstein Bequest Fund during the year were as follows:—

Balance, December 31, 1944	$2,546,38
Add Interest on Savings Account	27.78
Bequest from Trustees of Fund	540.42
Balance, December 31, 1945	$3,114.58

The income was verified from a photostatic copy of a statement of receipts and disbursements by Wells Fargo Bank & Union Trust Co., Trustee, as to the bequest, and the savings bank interest was verified from the pass-book.

(b) The change in the Benevolence Fund during the year is as follows:—

Balance, December 31, 1944	$7,293.50
Less Disbursements—Los Angeles County Physicians Aid Society	4,600.00
Balance, December 31, 1945	$2,693.50

Disbursements were verified from the basis of canceled checks and are in conformity with Minutes; and the balance was confirmed directly to us by the bank.

Deferred Charges—$591.66:

Details of this asset appear on the Balance Sheet and call for no further comment and, in our opinion, are correctly stated.

Deposit—United Air Lines—$425.00:

This represents a payment during the year to United Air Lines to secure air transportation.

Liabilities

Accounts Payable—$4,174.25:

The composition of this item appears on the Balance Sheet and is correctly stated.

Trust Accounts—$5,808.08:

This is a contra item to the amount of like assets shown in the Balance Sheet under "Assets," and has been commented on hereinbefore.

Surplus—$5,315.96:

This is the amount by which the total assets exceed the total liabilities at December 31, 1945. The only change during the year is the reduction of the Surplus by $68,361.10, representing excess of disbursements over receipts for the year 1945.

* * *

Statement of Income and Expenditure

This statement is presented in comparative form for the years 1945 and 1944, together with increases and decreases in the various items. Membership dues were checked by us to the statement of remittances sent in by County Societies. In addition, we selected several County Societies at random and wrote to them asking that they confirm to us the amount remitted by them.

From the basis of our examination and from replies received from County Societies, we are satisfied that these are being properly received and accounted, although, as understood by you, we made no attempt to check the dues to the membership cards on file. All income recorded as being received was verified to us as having been deposited in banks.

Income from advertisements in the "Journal" (California and Western Medicine) was test-checked by us to advertisements appearing in the November and December, 1945, issues of that periodical. It has been the practice to allocate to income of the "Journal" $3.00 for those members whose dues were paid for the entire year and $1.50 per member for those who joined the Association after July 1st.

Expenditures were verified from canceled checks and inspection of vouchers, where necessary, as well as from a review of the Minutes of the Council, Directors, etc., for authorization of expenditures, where necessary.

We are submitting a Comparative Statement of Expenditures for the years 1944 and 1945 in detail, showing the increases or decreases in the various items.

Very truly yours,

Hood and Strong.

* * *

CALIFORNIA MEDICAL ASSOCIATION
San Francisco, California
Balance Sheet
December 31, 1945

ASSETS

Cash			$32,292.32
In Banks		$23,068.33	
Commercial Accounts	$22,465.21		
Savings Accounts	603.12		
On Hand		9,183.00	
Petty Cash Fund		40.99	
Accounts Receivable			3,480.23
Journal Advertisers—Total		3,980.23	
Less Reserve for Doubtful Accounts		500.00	
Trust Funds			5,808.08
Morris Herzstein Bequest		3,114.58	
Benevolence		2,693.50	

Furniture and Fixtures—Nominal Value		1.00	
Deferred Charges		591.66	
Rent Paid in Advance	324.00		
Postage	267.66		
Deposit—United Air Lines		425.00	$42,598.29
LIABILITIES			
Accounts Payable		4,174.25	
Journal Production—Accrued Expense	2,607.05		
Collector of Internal Revenue — Withholding Tax	580.30		
Miscellaneous	986.90		
Deferred Income		27,300.00	
1946 Dues Received in Advance	27,300.00		
Trust Accounts		5,808.08	
Unexpired Balance of Income Received under Morris Herzstein Bequest	3,114.58		
Benevolence Fund	2,693.50		37,282.33
Surplus			$ 5,315.96
Representing the amount by which the total assets exceed the liabilities as of December 31, 1945:			
Balance, January 1, 1945		73,677.06	
Deduct		68,361.10	
Excess of Disbursements over Receipts for the Year 1945	68,361.10		

* * *

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, California

STATEMENT OF INCOME AND EXPENDITURE COMPARATIVE FOR YEARS ENDED DECEMBER 31, 1945 AND DECEMBER 31, 1944

INCOME

	YEAR ENDED DECEMBER 31, 1945	YEAR ENDED DECEMBER 31, 1944	INCREASE (DECREASE)
DUES AND GENERAL:			
Membership Dues—Less portion allocated to Journal Subscriptions	$ 96,403.05	$ 93,770.00	$ 2,633.05
California Medical Society—Services	600.00	600.00	
Interest earned	179.90	349.37	(169.47)
	$ 97,182.95	$ 94,719.37	$ 2,463.58
OFFICIAL JOURNAL, "CALIFORNIA AND WESTERN MEDICINE"			
Advertising	$ 51,933.45	$ 33,477.42	$ 18,456.03
Members' Subscription — allocated from dues	16,659.00	16,160.00	499.00
Cash Subscriptions	1,141.10	1,044.53	96.57
Reprint Sales, Etc.	254.58	31.20	223.38
	$ 69,988.13	$ 50,713.15	$ 19,274.98
TOTAL INCOME	$167,171.08	$145,432.52	$ 21,738.56
EXPENDITURE			
ADMINISTRATIVE	$ 64,157.17	$ 60,668.62	$ 3,488.55
SCIENTIFIC, EDUCATIONAL AND PUBLIC RELATIONS	128,713.64	40,541.23	88,172.41
OFFICIAL JOURNAL—'California and Western Medicine"	42,661.37	33,600.05	9,061.32
TOTAL EXPENDITURE	$235,532.18	$134,809.90	$100,722.28
NET INCOME OR (EXPENDITURE)	($68,361.10)	$10,622.62	($78,983.72)

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, California

EXPENDITURE COMPARATIVE FOR YEARS ENDED DECEMBER 31, 1945 AND DECEMBER 31, 1944

	YEAR ENDED DECEMBER 31, 1945	YEAR ENDED DECEMBER 31, 1944	INCREASE (DECREASE)
ADMINISTRATIVE:			
Salary—Association Secretary and Treasurer	$ 4,140.00	$ 3,825.00	$ 315.00
Salary — Executive Secretary	11,000.00	8,533.32	2,466.68
Salaries—Clerical	8,503.93	8,141.26	362.67
Travel Expense:			
Secretary	599.88	561.76	38.12
Officers	1,022.18		1,022.18
Council	2,020.63	2,455.96	(435.33)
Executive Committee	301.58		301.58
A.M.A. Delegates	3,158.45	2,122.75	1,025.70
Taxes—Payroll	307.58	348.82	(41.24)
Annual Meeting Expense	4,311.30	5,407,30	(1,096.00)
Legal Expense:			
Retainer Fee	5,333.33	4,000.00	1,333.33
Other Legal Expense	945.97	944.59	1.38
Rent	3,538.00	3,288.00	250.00
Office Supplies and Expense	2,499.71	1,312.16	1,187.55
Postage	610.67	726.23	(115.56)
Telephone and Telegraph	809.83	687.83	122.00
Council and Executive Committee	821.18	726.52	104.66
Special Session — House of Delegates	4.569.71	420.23	4,149.48
Miscellaneous	1,639.77	1,802.16	(162.39)
Contributions to the United Public Health League	8,023.47	15,364.73	(7,341.26)
	$ 64,157.17	$ 60,668.62	$ 3,488.55

* * *

	YEAR ENDED DECEMBER 31, 1945	YEAR ENDED DECEMBER 31, 1944	INCREASE (DECREASE)
SCIENTIFIC EDUCATIONAL AND PUBLIC RELATIONS:			
Contributions to Medical Libraries	$ 2,825.00	$ 2,745.00	$ 80.00
Public Policy and Legislation Expense	16,220.15	12,028.01	4,192.14
1945 Legislation	53,139.26		53,139.26
Department of Public Relations	15,747.19	8,388.95	7,358.24
Department of Public Relations—C.P.S. Promotion	28,588.13	9,698.15	18,889.98
Physicians' Benevolent Committee	5,604.00	5,498.00	106.00
Other Committees' Activities	6,589.91	2,183.12	4,406.79
	$128,713.64	$ 40,541.23	$ 88,172.41

* * *

	YEAR ENDED DECEMBER 31, 1945	YEAR ENDED DECEMBER 31, 1944	INCREASE (DECREASE)
OFFICIAL JOURNAL—"CALIFORNIA AND WESTERN MEDICINE":			
Salary—Editor	$ 4,600.00	$ 4,249.97	$ 350.03
Printing	28,365.62	20,441.06	7,924.56
Advertising Commission	5,836.67	4,368.04	1,468.63
Wrapping and Mailing	1,856.95	2,053.26	(196.31)
Illustrations	297.84	282.80	15.04
Supplies, Expense and Office Postage	1,468.23	1,805.21	(336.98)
Discounts and Collection Expense	236.06	399.71	(163.65)
	$ 42,661.37	$ 33,600.05	$ 9,061.32
TOTAL ALL EXPENDITURE	$235,532.18	$134,809.90	$100,722.28

CALIFORNIA MEDICAL ASSOCIATION AND TRUSTEES OF CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)

San Francisco, California

COMBINED COMPARATIVE BALANCE SHEET

ASSETS	CALIFORNIA MEDICAL ASSOCIATION	TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION	COMBINED DECEMBER 31, 1945	COMBINED DECEMBER 31, 1944	INCREASE (DECREASE)
Cash	$32,292.32	$ 26,141.38	$ 58,433.70	$ 79,471.27	$(21,037.57)
Marketable Securities		125,004.36	125,004.36	92,592.41	32,411.95
Accounts Receivable	3,480.23		3,480.23	2,283.48	1,196.75
Endowment Fund		260.73	260.73	258.15	2.58
Benevolence Fund	2,693.50	13,452.25	16,145.75	13,945.28	2,200.47
Trust Fund	3,114.58		3,114.58	54,474.88	(51,360.30)
Furniture Equipment, etc.	1.00		1.00	1.00	
Deferred Charges	591.66		591.66	1,051.88	(460.22)
Deposit—United Air Lines	425.00		425.00		425.00
	$42,598.29	$164,858.72	$207,457.01	$244.078.35	($36,621.34)
LIABILITIES, RESERVES AND SURPLUS					
Accounts Payable	$ 4,174,25		$ 4,174,25	$ 2,701.60	$ 1,472.65
Members' Contribution to Endowment Fund		260.73	260.73	258.15	2.58
Benevolence Fund	2,693.50	13,452.25	16,145.75	13,945.28	2,200.47
Trust Account	3,114.58		3,114.58	54,474.88	(51,360.30)
Deferred Income	27,300.00		27,300.00	660.00	26,640.00
Surplus	5,315.96	151,145.74	156,461.70	172,038.44	(15,576.74)
	$42,598.29	$164,858.72	$207,457.01	$244,078.35	($36,621.34)

II

Trustees of the California Medical Association (A Corporation)

Report of Examination

December 31, 1945

No. 1372-1544 January 21, 1946

Trustees of the California Medical Association (a Corporation),

San Francisco, California.

Dear Sirs:

Pursuant to your instructions, and following our attention for prior years, we have made an examination of your accounts for the year 1945, and, upon the conclusion thereof, have prepared and present hereinafter the following statements:—

Trustees of the California Medical Association (a Corporation) and California Medical Association:—
  Combined Comparative Balance Sheet—
  December 31, 1945 and December 31, 1944
Trustees of the California Medical Association (a Corporation):—
  Balance Sheet—December 31, 1945
  Statement of Income and Expenditure—
    Comparative for the Years Ended December 31, 1945 and December 31, 1944

We have also made an examination of the accounts of California Medical Association and have rendered a separate report thereon.

The following comments are submitted in amplification of the various items appearing in the statements submitted herein and indicate, generally, the scope of our examination:—

Trustees of the California Medical Association (a Corporation) and California Medical Association Combined Comparative Balance Sheet—
December 31, 1945 and December 31, 1944

This statement exhibits, in condensed form, the combined assets and liabilities of both organizations. The assets and liabilities of the Trustees of the California Medical Association will be discussed in detail hereinafter, and a separate report is being presented as to the assets and liabilities of the California Medical Association.

Trustees of the California Medical Association (a Corporation)

Balance Sheet—December 31, 1945

Assets

Cash—$26,141.38:

This amount was verified from the basis of certificates received by us from the depositaries.

Investments—$125,004.36:

These consist of government securities of a par value of $124,000.00, plus accrued interest of $1,004.36. The details of these securities are as follows:—

$ 5,000.00	p.v. U. S. Treasury Bonds 3⅛%	1949-52
10,000.00	p.v. U. S. Treasury Bonds 2¾%	Mar. 15, 1948
10,000.00	p.v. U. S. Treasury Bonds 2½%	1949-53
5,000.00	p.v. U. S. Treasury Bonds 2½%	Dec. 15, 1945
15,000.00	p.v. U. S. Treasury Bonds 2½%	1964-69
20,000.00	p.v. U. S. Treasury Bonds 2½%	1965-70
14,000.00	p.v. U. S. Treasury Bonds 2½%	1966-71
25,000.00	p.v. U. S. Treasury Bonds 2½%	1966-71
20,000.00	p.v. War Savings Bonds 2½%	12 years
$124,000.00		

All the bonds were inspected at your safe deposit vault in the presence of Drs. Kress, Gilman and Mr. Hunton.

Endowment Fund—$260.73:

The only change in this account during 1945 was the addition of savings account interest of $258.00. The balance was confirmed directly to us by the bank. This fund is offset by a like amount under "Liabilities and Surplus."

Benevolence Fund—$13,452.25:

This amount consists of monies in trust for the California Medical Association, and the account was started in 1942, in conformity with the Minutes of the Association.

The changes in this account for the year 1945 are as follows:—

Balance, December 31, 1944		$ 6,651.78
Add		6,800.47
Interest on Savings Account	$ 50.00	
Donation from Woman's Auxiliary	1,146.47	
Contribution by Members	5,604.00	
Balance, December 31, 1945		$13,452.25

This balance was verified by direct confirmation from the depositary. This fund was offset by a like amount under "Liabilities and Surplus."

LIABILITIES AND SURPLUS

MEMBERS' CONTRIBUTION TO ENDOWMENT FUND ....$ 260.73:

BENEVOLENCE FUND $13,452.25:

These items are contra to the same funds shown under assets and have been discussed hereinabove.

SURPLUS—$151,145.74:

This represents the amount by which the total assets exceed the liabilities at December 31, 1945.

The surplus balance at December 31, 1944, was $98,361.38 and the changes during the year represent additions as follows:—

Net Income for the Year 1945	$ 2,606.65
Transfer of Indemnity Fund	50,177.71
	$52,784.36

The balance of the Indemnity Fund at December 31, 1944, was $51,928.50. This was increased by interest on bonds and savings accounts in the amount of $684.21, leaving $52,612.71 from which amounts were refunded to contributing members of $2,435.00, leaving a balance of $50,177.71.

By resolution of the Trustees of the California Medical Association on August 12, 1945, "inasmuch as there was no further purpose to be served by continuing the Indemnity Defense Fund, the assets of this trust fund were transferred to the corporation. . . ." Before the transfer, the trustees arranged that payments be made from the fund to each contributing member of the Defense Fund who was still living and an active member of the California Medical Association and who had not assigned his interest in such fund to the corporation. This was done to the extent of $2,435.00 and there is a possible further liability of $150.00 to four members who have not been heard from.

STATEMENT OF INCOME AND EXPENDITURE

This has been exhibited in comparative form for the years 1945 and 1944, together with increases and decreases in the various items. We satisfied ourselves, to the extent practicable, that all income has been correctly accounted and that the expenditures have been proper.

Very truly yours,

HOOD AND STRONG.

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)

San Francisco, California

* * *

BALANCE SHEET DECEMBER 31, 1945

ASSETS				
CASH			$ 26,141.38	
Bank of America, N.T. & S.A.		$ 10,947.42		
Commercial Account	$4,430.05			
Savings Account	6,517.37			
Wells Fargo Bank—Savings Account..		7,618.22		
American Trust Co.—Savings Account.		7,575.74		
INVESTMENTS			125,004.36	
U. S. Government Securities		124,000.00		
Accrued Interest		1,004.36		
ENDOWMENT FUND			260.73	
Bank of America, N.T. & S.A. — Savings Account		260.73		
BENEVOLENCE FUND			13,452.25	
Crocker First National Bank — Savings Account		13,452.25		$164,858.72

* * *

LIABILITIES AND SURPLUS			
MEMBERS' CONTRIBUTION TO ENDOWMENT FUND		260.73	
BENEVOLENCE FUND		13,452.25	13,712.98
SURPLUS			$151,145.74
Representing the amount by which the total assets exceed the liabilities as of December 31, 1945:			
Contributed Surplus received from California Medical Association..		75,000.00	
Earned Surplus..		25,968.03	
Balance, January 1, 1945	23,361.38		
Net Income for Year 1945	2,606.65		

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION) AND CALIFORNIA MEDICAL ASSOCIATION

COMBINED COMPARATIVE BALANCE SHEET

ASSETS	TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION	CALIFORNIA MEDICAL ASSOCIATION	COMBINED DECEMBER 31, 1945	COMBINED DECEMBER 31, 1944	INCREASE (DECREASE)
Cash	$ 26,141.38	$32,292.32	$ 58,433.70	$ 79,471.27	($21,037.57)
Marketable Securities	125,004.36		125,004.36	92,592.41	32,411.95
Accounts Receivable		3,480.23	3,480.23	2,283.48	1,196.75
Endowment Fund	260.73		260.73	258.15	2.58
Benevolence Fund	13,452.25	2,693.50	16,145.75	13,945.28	2,200.47
Trust Fund		3,114.58	3,114.58	54,474.88	(51,360.30)
Furniture, Equipment, Etc.		1.00	1.00	1.00	
Deferred Charges		591.66	591.66	1,051.88	(460.22)
Deposit—United Air Lines		425.00	425.00		425.00
	$164,858.72	$42,598.29	$207,457.01	$244,078.35	($36,621.34)
LIABILITIES—RESERVES AND SURPLUS					
Accounts Payable		$ 4,174.25	$ 4,174.25	$ 2,701.60	$ 1,472.65
Members' Contribution to Endowment Fund	$ 260.73		260.73	258.15	2.58
Benevolence Fund	13,452.25	2,693.50	16,145.75	13,945.28	2,200.47
Trust Account		3,114.58	3,114.58	54,474.88	(51,360.30)
Deferred Income		27,300.00	27,300.00	660.00	26,640.00
Surplus	151,145.74	5,315.96	156,461.70	172,038.44	(15,576.74)
	$164,858.72	$42,598.29	$207,457.01	$244,078.35	($36,621.34)

Transfer of Indemnity Fund..		50,177.71	
Balance of Fund	52,612.71		
Less amount refunded to contributing members	2,435.00		

* * *

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)
San Francisco, California
STATEMENT OF INCOME AND EXPENDITURES
COMPARATIVE FOR THE YEARS ENDED
DECEMBER 31, 1945 AND DECEMBER 31, 1944

	YEAR ENDED DECEMBER 31ST		INCREASE
INCOME:	1945	1944	(DECREASE)
Interest on Bonds.......	$2,718.99	$1,967.62	$751.37
Interest on Saving Accounts	58.66	69.17	(10.51)
	$2,777.65	$2,036.79	$740.86
EXPENDITURE:			
Audit Fee	$ 140.00	$ 126.00	$ 14.00
Miscellaneous	31.00	31.00	
	$ 171.00	$ 157.00	$ 14.00
NET INCOME	$2,606.65	$1,879.79	$726.86

REPORT OF THE EXECUTIVE SECRETARY

To the President and the House of Delegates:

Your Executive Secretary presents the following report to cover his activities during the calendar year 1945 and the early months of 1946:

1. *General.* The C.M.A. office has been maintained to the best of our ability under continuing conditions which make it impossible to secure needed equipment. Such equipment, including new typewriters and mechanical attachments for mimeographing facilities, is now on order but not yet delivered. The office staff remains the same as a year ago, four capable, willing and loyal assistants, all of whom have remained with the Association throughout the entire war period. Our thanks and appreciation are due them.

2. *Financial.* The Association spent $68,361 more than it took in during 1945. This compares with expenditures of $10,623 less than revenues for 1944. Total revenues for 1945 were $167,170, compared with $145,433 for 1944; revenues of California and Western Medicine for 1945 were $53,329, including $51,933 from advertising, compared with total revenues of $34,553, including $33,477 from advertising, for 1944. The sharp increase in advertising and journal revenues last year resulted from increased advertising rates, which were adjusted late in 1944 and made effective January 1, 1945.

Administrative expenses for 1945 totaled $64,157, compared with $60,669 for the preceding year. Journal expenses were $42,661, against $33,600, practically all of the increase resulting from higher printing costs of $28,366, compared with $20,441 for 1944. Part of the rise in printing costs came from higher charges by the printer and part from increased size in the journal itself.

Expenses chargeable to scientific, educational and public relations activities amounted to $128,714, compared with $40,541 for 1944. The increase in these figures came from a new item of $53,139 for "1945 legislation" and a rise from $9,689 for 1944 to $28,588 for 1945 for "C.P.S. Promotion." The legislative expenditure was voted by the Council in line with resolutions adopted at the January, 1945, special session of the House of Delegates, and the C.P.S. promotional expenditure was in line with earlier resolutions by the Council. Additional budget items have been prepared to cover these subjects for the coming year.

During 1945 the old Indemnity Defense Fund was completely liquidated, this transaction resulting in the transfer to the Trustees of the C.M.A. of a net amount of $50,178 in cash and Government bonds. This sum is now held by the Trustees of the C.M.A. for corporate purposes established in the incorporation papers of this body.

The Association completed its 1945 activities without the necessity of borrowing funds, despite the sizeable expenditure of money beyond cash revenues for the year. The Association is now in a comfortable cash position, with surplus funds invested in U. S. Treasury bonds and sufficient cash on hand to meet all foreseeable obligations and to provide for contingencies.

At the meeting of the Council on February 1, 1946, the Executive Secretary suggested that the Association's fiscal year be made to start on July 1 of each year. This was voted by the Council and new budgets will be based on that fiscal period. It is believed that this arrangement will make possible the establishment of a budget more nearly in keeping with the actual operating period of the Association, which begins annually with the meeting of the House of Delegates, usually early in May.

3. *California and Western Medicine.* The journal was produced at a net profit of $10,688 for 1945, compared with a net profit of $953 for 1944. This showing came principally from increased advertising revenues under the new rate structure. For 1946 we already have advertising contracts on hand in excess of the 1945 total and all indications point to a record year in this department.

Advertising solicitation, particularly on national accounts, has been subjected to some changes in the past 12 months. The Coöperative Medical Advertising Bureau maintained by the A.M.A. has represented our journal for a number of years and in recent months has made some internal changes which may very easily react adversely to the best interests of our journal. The Executive Secretary, as publisher and business manager of the journal, has been granted full authority by the Council to handle this matter in his best judgment. To date no changes in this department have been made but some changes are indicated and will be put into effect when and if they appear practicable.

4. *Annual Session.* The 1946 Annual Session will see the resumption of technical exhibits. The exhibitors this year have contracted for more space and at a higher revenue to the Association than in any year in the past. It is hoped that those members attending the Annual Session will visit all the exhibits and express their appreciation to the exhibitors for their loyal support of our meetings.

5. *The United Public Health League.* Your Executive Secretary has served as Executive Secretary of the United Public Health League since its organization in January, 1944. The League has made a place for itself in national legislative circles and this year will have a real opportunity for service in Senate hearings on the Wagner-Murray bill and other national legislative proposals. The Council has generously voted to support the League and it is believed that definite dividends will be returned by this organization when real support is needed in the Federal legislative field.

6. *Public Policy and Legislation.* Your Executive Secretary has coöperated with the chairman of Public Policy and Legislation to the fullest extent in the past year. During the long 1945 session of the State Legislature it was necessary for him to spend considerable time in Sacramento and to appear before Assembly committees on numerous occasions.

7. *Industrial Medical Fees.* Your Executive Secretary was named in July, 1944, as the C.M.A. representative on a "Study Committee" appointed by the Industrial Accident Commission to work toward the establishment of a schedule of medical and surgical fees acceptable to the physicians, employers and insurance carriers alike. This committee was deliberately made top heavy with representatives of insurance carriers and more recently has been expanded to include representatives of the osteopathic profession, of hospitals, labor and—late in 1945—of the chiropractic group. In a supplemental report to the House of Delegates in 1945, the Executive Secretary expressed his opinion that this study group would probably not have any real accomplishments and that the Association should seek adjustment of its grievances through legislation. This opinion is reiterated at this time inasmuch as no real progress has been shown by the study committee in the past 12 months and none appears likely under existing conditions. If the physicians of California are to receive a fair reward for their services under the compensation laws, it is felt that new legislation must be enacted to put real authority in the hands of the Industrial Accident Commission to establish, enforce and review medical and surgical fee schedules and to prevent rebates, fee-cutting, fee-splitting and other evils long associated with this work.

8. *Malpractice Insurance.* For the past two years this subject has been under study by the Executive Secretary at the direction of the Council and the House of Delegates. This study was necessarily interrupted in 1945 by the more pressing demands in the legislative field but a solution should be sought at the earliest possible date.

The study of the handling of malpractice insurance in other states indicates clearly that where group malpractice coverage is secured through recognized insurance carriers, and where there is a well-defined coöperation between the carriers and the medical profession, premium rates for this type of insurance can be reduced to mutually satisfactory levels.

Without entering into too great detail; it is the recommendation of the Executive Secretary that suitable arrangements be solicited as soon as possible for the establishment of group malpractice coverage in California, including the inauguration of a clearly-defined and recognized defense organization within the C.M.A.

9. *Conclusion.* This report must be concluded with the kindest thanks to the members of the Council, the officers of the C.M.A. and the county societies, our legal counsel and the members of the Association as a whole. Their coöperation has been of the greatest possible help in the coördination of efforts necessary for smooth and successful operation of a large Statewide association such as the C.M.A.

Respectfully submitted,
JOHN HUNTON, *Executive Secretary.*

REPORT OF THE EDITOR

To the President and the House of Delegates:

Reports submitted during the last five war years have referred to the difficulties to which publications in general have been subjected. Mention was made of governmental paper restrictions, insufficient man power in job printing establishments, and other conditions that have made prompt appearance of a monthly publication at a stipulated date almost impossible. In addition, post office facilities have been handicapped by man power shortage. It is to be hoped that in the months ahead, some of these wartime difficulties will be eliminated.

During the calendar year 1945, major articles that have appeared in CALIFORNIA AND WESTERN MEDICINE, by groups and number included:

Editorials	32
Editorial Comment Articles	19
Scientific and General (Original) Articles	78
Case Report Articles	3
Major State Association Committee Reports	144
Major Miscellany Department Reports	65

Several years ago, the Council put a ceiling limit on the number of text pages in OFFICIAL JOURNAL, thus limiting the space available for original articles presented at annual sessions or before component county societies. This ruling has led an increasing number of annual session essayists to request the privilege of having their papers appear in other publications to make certain that the papers would be printed, and at a comparatively early date, while the subject matter of their text was still of pertinent interest.

During the last year the number of text pages in CALIFORNIA AND WESTERN MEDICINE, exclusive of the Pre-Convention section and the House of Delegates minutes, have totaled 605, making an average of 50 5/12 pages for each month. The Council had stipulated that a minimum average of 50 pages should be allotted in each month's issue for text articles and items, the remainder of the publication to be given over to advertisements.

During 1945, as in former years, the Association became indebted to members of the Editorial Board who gave generously of their time in perusing and giving opinions concerning manuscripts that had been submitted for possible publication in the OFFICIAL JOURNAL.

A constituent state medical association that has more than 7,000 members has many organization problems that must be called to the attention of members. With a ceiling limit in number of about 50 text pages, and with war effort, legislative and other pertinent news crowding in for space, it followed, as stated above, that the number of pages for original articles was necessarily limited; with decisions by the Editorial Board as to acceptance of papers, that were not always to the liking or happiness of contributing members.

With this present report, your editor makes his swan song, since in May, 1946, he will have more than passed three score and ten in years, and will then retire from editorial supervision of CALIFORNIA AND WESTERN MEDICINE. To have had the privilege since 1927 of having been the editorial spokesman for the California Medical Association, and to have written in these 19 years every editorial that has appeared in the OFFICIAL JOURNAL, has given him an opportunity for service for which he wishes to express his personal thanks. He has been appreciative also, of the latitude granted him in the selection of contents and make-up of text pages. In certain respects, CALIFORNIA AND WESTERN MEDICINE has differed in style from some state medical journals, but an effort has been made constantly to have it retain a form that would make for its convenient and useful perusal. To the many C.M.A. members who have aided him in his work, the editor makes his grateful acknowledgments.

To an editor, each issue of his publication takes on in some respects, the aspects of a brain-child, with all the lure that goes with such experiences. To have had the opportunity of having enjoyed such realizations, month by month, over practically a score of years, has been a pleasant privilege.

In signing off, your editor wishes again to thank all who, over the years, have aided him with their kindly and generous coöperation.

Respectfully submitted,
GEORGE H. KRESS, *Editor.*

REPORT OF THE LEGAL DEPARTMENT

To the President and the House of Delegates:

The Legal Department submits the following report covering the period from the last session of the House of Delegates to the present time:

1. *General.* The recurrence of the drive for government medicine, both within California and at Washington, has vitally affected all of the activities of the California Medical Association during the past year, including the Legal Department. Our day-by-day activities have encompassed too many fields and have been too voluminous to be enumerated in a report, unless it extend to tedious lengths. In carrying out our functions, we have realized that both the Council and the House of Delegates deem it a matter of overwhelming necessity for the medical profession, both in California and nationally, to have a strong, united and coördinated organization. It is the stated policy of the California Medical Association—which we have done our best to implement and promote—that the interests of the medical profession, both in California and nationally, require an aggressive four-point program, involving (a) medical care to the public on a prepayment basis, (b) close, accurate and constant contact between the medical profession and the legislative and executive branches of the Federal Government and the State government, (c) an honest, efficiently-administered public relations program, and (d) that all activities be completely coördinated so that the maximum effect is obtained. To carry out this policy, constant action and bold decisions are a matter of necessity. Caution and avoidance of risk must be subordinated to an effective fundamental policy. We have premised all of our activities on these statements of principle.

2. *Legislation.* At the time of the May, 1945, meeting of the House of Delegates, a regular session of the Legislature was in progress. Until the adjournment of the session late in June, 1945, we devoted the major portion of our time to assisting the Committee on Public Policy and Legislation in opposing various bills inimical to the interests of both the public and the profession. These included compulsory health insurance, compulsory hospital insurance, and various and sundry bills aimed at lowering the standards of medical care. The 1945 legislative session was particularly burdensome because various interests, such as naturopaths, chiropractors and others, increased their usual efforts to break down the standards of medical care, apparently proceeding on the theory that the California Medical Association was so busy with compulsory health insurance that it would not have time to oppose other matters. It was necessary for us to prepare amendments against and oppose no less than fifteen different bills of the character described, all in the space of a few weeks during the latter part of the session.

A special session of the Legislature was held during January and February, 1946. The major issue for the special session was a so-called disability benefits bill sponsored by Governor Warren and the State Federation of Labor. This bill was passed by the Legislature. As it is described in detail elsewhere, we will not elaborate on it except to state that, as enacted, it places an undue burden on the practicing physician, who is required to certify with respect to the ability or inability of a patient to perform his customary work. We intend, under the direction of the Council, to press for administrative regulations that will be workable and for amendment of the law at the next legislative session, in order to correct this defect. The Sickness Disability Law also permits chiropractors to certify as to disability, and we intend to urge elimination of chiropractors at the next session. At the special session, the Legislature also enacted the Hospital Survey Bill, which permits a preliminary survey of the State's hospital needs, so that the State will be in a position to act under the Federal Hospital Construction Bill, if and when it becomes law.

We have at all times endeavored to aid and assist the Committee on Public Policy and Legislation, and to be at its command whenever needed.

3. *Advisory Planning Committee.* As directed by the House of Delegates, we have served on this committee and have attended all of its meetings during the year. Its activities have been very extensive, and have been reported from time to time to the Council and are published in the minutes of the Council.

4. *Special Committees.* The most active special committee of the Association during the past year has been the "Special Committee to Study Prepayment Medical and Hospital Plans." Upon request, we have attended several of the meetings of this committee and have endeavored to assist and advise it with respect to the legal aspects of prepayment medical and hospital plans.

We also undertook considerable research and submitted a full opinion to the special committee appointed to study A.A.P.S., at its request.

5. *Fee Schedule in Compensation Cases.* At the last annual meeting we reported the adoption by the Industrial Accident Commission of a 15 per cent increase in the existing fee schedule in workmen's compensation cases to apply for the duration of the war. During the past year a number of instances have been called to our attention where an insurance company has refused to compensate physicians rendering services on the basis of the 15 per cent increase, and have attempted to maintain the old rate. In each case, a letter of protest was delivered to the insurance company involved, and in each instance the company revised its compensation payable so as to include the 15 per cent increase. At the Council meeting held in October, 1945, a new and revised Industrial Accident Commission fee schedule was approved for submission to the Industrial Accident Commission. A petition incorporating the revised fee schedule was prepared and filed with the Commission in December, 1945. To date no action has been taken by the Commission on the Association's petition. However, at the last session of the Legislature on Interim Committee on Insurance was created by the Assembly, and in the resolution creating such committee a paragraph was included authorizing it to study and report to the Assembly at the next legislative session the entire subject of medical care under the Workmen's Compensation Act, including the adequacy of distribution of medical care and the fairness of compensation paid to physicians. At the present time the Assembly Interim Committee on Insurance has scheduled a public hearing on the subject of medical fees in industrial accident cases, to be held in Los Angeles on March 22nd. At that time representatives of the Association will point out to the committee the present inadequacies, both in medical fees and in the provisions of the Workmen's Compensation Act. It is hoped that some action, either by the commission or by the Legislature, may be taken.

6. *Sales Tax on Roentgenograms.* In 1945 the State Board of Equalization decided to levy a sales tax upon x-ray film furnished by physicians or by lay laboratories, either to the patient or to another physician. By direction of the Council, a protest was filed with the State Board of Equalization objecting to the imposition of the sales tax upon any portion of the fee charged by a radiologist even though the charge included the delivery to the patient or his referring physician of a roentgenogram. The basis of the protest was that the fee charged

by licensed physicians practicing radiology was solely referable to professional services rendered, and did not in any way involve the transfer of tangible personal property at retail.

After conference with the counsel for the State Board of Equalization and submission of information and authorities supporting the protest, the Board ruled that where ownership of the "x-ray picture or negative" is not transferred no sales tax is incurred. Under the customary practice of doctors of medicine specializing in radiology, the film remains the property of the radiologist. Hence, for all practical purposes, the interpretation of the State Board of Equalization has now been changed so that a sales tax is *not* imposed upon doctors of medicine specializing in radiology.

7. *American Cancer Society, California Division.* During the past year the nine members of the Cancer Commission have also acted as directors of an unincorporated association operating in the State of California under the name of American Cancer Society Field Army. At the request of Dr. Lyell C. Kinney, Chairman of the Cancer Commission, we assisted in the reorganization of the Cancer Society and in the formation of a nonprofit corporation under the laws of the State of California, to be known as American Cancer Society, California Division. The Board of Directors of this corporation consist of the nine members of the Cancer Commission of the California Medical Association and six leading citizens of the State. The new corporation is affiliated with the American Cancer Society, Inc., a New York corporation which operates nationally, and its purposes are to assist in the control of cancer in California and to aid in the establishment of means to discover and cure cancer approved by the component county societies.

8. *Opinions.* During the year we rendered a number of miscellaneous opinions to members on questions which arose in connection with their practice. Among the subjects covered were: sterilization; proper execution of birth certificates; social security tax; necessity of autopsy permits; disciplinary procedure in various county medical societies; and admission of new members. We have also passed upon malpractice insurance policies held by a number of members.

In closing this report, we desire to express our gratitude for the kind and thoughtful action of the Council at its 1945 organization meeting in directing that we be notified of "the appreciation of the Council for the excellent service that had been rendered . . . to the medical profession of California." Representing the medical profession is both stimulating and a tremendous responsibility. The lasting compensation for such service is not the monetary reward—it is the sense of accomplishment in working for the betterment of medicine. As we have done in the past, we shall continue to strive for the *right* to feel that we have contributed our bit.

Respectfully submitted,
Peart, Baraty & Hassard, *General Counsel.*

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties

To the President and the House of Delegates:

The Societies of the five Counties comprising the First District have been working earnestly on the problem of State medicine. It is gratifying that all representatives from these Counties stood with us in the last Legislature.

A great deal has been done toward locating returned veterans, although office space has been difficult to procure.

Several new members have joined our medical Societies. It is hoped that the great influx of physicians will not fill our ranks to overflowing.

Many newcomers have been interviewed, and in such interviews we have endeavored to protect the interests of veterans who are now returning to their practices in our localities.

Respectfully submitted,
H. A. Johnston, *Councilor,*
First District.

SECOND COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

Your Councilor for the Second District has the following to report for the previous year.

Your Councilor attended all of the meetings of the California Medical Association Council. It being his first year on the Council, he became acquainted with the many duties and with the work required. In addition to the Council meetings, your Councilor has attended all but one of the meetings of Dr. Chandler's Special Committee, appointed by the House of Delegates, to investigate all phases of California Physicians' Service and other prepaid voluntary insurance plans. Their report will be given to the House of Delegates in May, 1946.

Many very interesting subjects have been taken up by the Council, not the least, of course, is our old subject of compulsory health insurance.

The minutes of the Council have been published in California and Western Medicine at regular intervals for your study. I only hope as a Councilor that all of the delegates' alternates will attend the House of Delegates Meeting next May.

Respectfully submitted,
Jay J. Crane, *Councilor,*
Second District.

THIRD COUNCILOR DISTRICT

Kern, San Luis Obispo, Santa Barbara, Ventura, and Inyo-Mono Counties

To the President and the House of Delegates:

The Third Councilor District and its component societies take pleasure in welcoming home the majority of its members who have been in the armed forces. About 90 per cent have returned and resumed their former positions in the district. Increased population in the area still causes a heavy load on nearly all doctors. The component societies are all very active and quite well informed regarding the present trends in the social structure.

Respectfully submitted,
H. E. Henderson, *Councilor,*
Third District.

FOURTH COUNCILOR DISTRICT

Fresno, Madera, Kings, Tulare, Merced, Mariposa, Calaveras, San Joaquin, Tuolumne, and Stanislaus Counties

To the President and the House of Delegates:

Nearly all of the C.M.A. members from this district who have served in the armed forces have returned and are welcomed by the home guard of older practitioners. These men who have just discarded their uniforms, and are trying to reëstablish themselves in the private practice of medicine have many problems to solve, housing facilities for their families, office space, and equipment, and hospital service for their patients are discouraging difficulties. All members that can help these men, who have served our country usually at great personal loss, are urged to give every aid possible. This is an opportunity to apply the golden rule and help cement our profession into unity of friendship and purpose to win the impending struggle to preserve the American system of medical practice.

The membership has been asked to help in the education of the public on voluntary prepaid medical care and hospital service.

Respectfully submitted,
A. E. Anderson, *Councilor,*
Fourth District.

FIFTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Cruz, and Santa Clara Counties

To the President and the House of Delegates:

The component counties of the 5th Councilor District have been visited or contacted since the last meeting of the House of Delegates.

Most of the members that have been serving in the armed forces have now returned to their former offices and many new men have come into the district.

It would be interesting to know that in Santa Clara County District, eighty-two (82) new members have come in since the onset of war. Thirty-six (36) of these eighty-two have served in the armed forces. Six (6) are women. This is an indication as to what has taken place in the whole district.

There is no doubt that there has been an increase in the population which will compensate for the number of returnees and new men that are now practicing.

Good programs have been held throughout the district during the year and the interest of the physicians in this district has been kept up in the local component societies.

The woman's auxiliary have been active in assisting the doctors throughout the year.

Respectfully submitted,
R. S. Kneeshaw, *Councilor,*
Fifth District.

SIXTH COUNCILOR DISTRICT

San Francisco County

To the President and the House of Delegates:

During the past year, the San Francisco County Medical Society has continued to work under a curtailed scientific program and has devoted a large portion of its activities to the transition from war to peacetime status.

The members returning from service in the armed forces have had numerous problems confronting them which the Society has made an effort to assist in solving.

Office space available has been, and is still, inadequate. Members of the Society have taken returning veterans into their offices, and the Society has made every effort possible to prevail upon building owners to recognize the rights of the returning service men.

Special committees to deal with the problems of the returning veteran have been appointed, and the special Service Fund has rendered assistance wherever possible.

During the past year, the Society employed a full time executive secretary, Mr. Frank J. Kihm. It is believed that the functions of the Society will be more efficiently carried out.

The Irwin Memorial Blood Bank has continued to serve the community and the surrounding area in splendid fashion.

Respectfully submitted,
John W. Cline, *Councilor,*
Sixth District.

SEVENTH COUNCILOR DISTRICT

Alameda and Contra Costa Counties

To the President and the House of Delegates:

In my reports for the past two years I have mentioned the shortage of hospital beds in my district. Now this shortage has become alarmingly serious. The increase in population for the city of Oakland alone, during the past five years is almost 100,000.

Doctors returning from the service have had considerable difficulty in obtaining office space: there is still an acute shortage of office space.

The above two facts have caused considerable dissatisfaction and resentment.

I feel that now, more than ever before, because of legal problems facing the entire medical profession we must have unity and harmony, and to obtain this we must have, first of all, knowledge of what is going on both inside and outside of the profession. With this in mind both Alameda and Contra Costa Medical Associations will continue to send their secretaries to all California Medical Association Council meetings.

I wish to take this opportunity to compliment Mr. Rollen W. Waterson, Executive Secretary of the Alameda County Medical Association, for the great progress he has made in developing the organization of Alameda County. He will be able to render his services to Contra Costa County in the near future.

Respectfully submitted,
Lloyd Kindall, *Councilor,*
Seventh District.

EIGHTH COUNCILOR DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties

To the President and the House of Delegates:

The past year has been one of unusual legislative activity in Sacramento beginning in January of 1945 with attempts to pass compulsory health insurance and continuing through the special session of the Legislature in 1946 with its sickness insurance bills. As Councilor of the 8th District, I have assisted the C.M.A. legislative committee in opposing the above legislation chiefly through local coöperation. In addition, I have attended all regular and special meetings of the C.M.A. Council during the past year.

With improvement in transportation it is hoped that the annual visit to component medical societies of the 8th District which was interrupted during the period of hostilities will be resumed this year.

Respectfully submitted,
Frank A. MacDonald, *Councilor.*
Eighth District.

NINTH COUNCILOR DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties

To the President and the House of Delegates:

All through the year of 1945 all doctors in California were as busy as during the previous year, taking care of the increased population coming into this area from distant communities.

Your Councilor was able to visit in Sonoma, Napa and Marin counties only.

On Saturday, August 18, 1945, doctors of Marin, Napa and Solano counties were the guests at a tri-county meeting as the guest of the Sonoma County Medical Society at Fetters Hot Springs.

There were no acute medical problems in any of the counties except Solano. The Stowe-Lipsett Clinical Group of Oakland, after short lived activity in the local Housing Units decided to discontinue their service. Since they discontinued and decided to continue on an active basis only in the Berkeley district, the Permanente Foundation has obtained a foothold in Solano County by furnishing prepaid medical service to employees of Mare Island Naval Shipyard who reside in the Housing Units. They have gone one step further than this and offer medical service to anyone living in the Vallejo area whether or not they are employed by the Shipyard.

We understand this medical service is not offered by the Permanente Foundation itself, but the medical service is guaranteed under the name of Dr. Sidney Garfield. The secretary of the Solano County Medical Society has recently requested information from Peart, Baraty and Hassard concerning this activity. The Society feels that the Housing Authority is exceeding its authority when it rents quarters to the Garfield group for $1.00 a month, plus its utilities. In as much as California Physicians' Service received the same treatment that is being accorded Dr. Garfield, etc., the Housing Authority would seem to be fully justified. However, that may be, C.P.S. is a *nonprofit* organization while Dr. Sidney Garfield is in the practice of medicine, with his associates, for profit.

C.P.S. has withdrawn its medical service in the last of the Housing Units, namely, Chabot, as of January, 1946. It would appear to your Councilor that their activities in Chabot might very well have been continued for at least six or twelve months and would have automatically eliminated the Garfield group. The ultimate outcome of Garfield-Permanente in this area is problematical and brings a rather serious and irritating condition in the practice of medicine in Solano County. Medical Service in the Vallejo area is just as much of a problem for the local men of the C.M.A. as it has been for the past four years because the population of Vallejo and its environ continues in the neighborhood of 100,000.

Since V-J day three doctors have settled in the area, one of whom took over the practice of Dr. A. V. Doran, deceased member.

Respectfully submitted,
John W. Green, *Councilor,*
Ninth District.

REPORTS OF COUNCILORS-AT-LARGE

To the President and the House of Delegates:

As a Councilor-at-Large of the California Medical Association for the year nineteen hundred forty-five and forty-six, I have attended all of the Council meetings.

The year nineteen hundred and forty-six promises to be a year of great importance to the medical fraternity, because this year is the opportune time in which we can more or less determine the character of medical practice in the future.

Our prime purpose during the year nineteen forty-six should be to thrust forward with all of the combined strength and ability that we can summon, to further those forms of medical practice which are controlled by the medical profession and not by politically minded bureaus or commissions.

It is certain that our efforts must be felt in the political campaign which ends on Tuesday, November 5, 1946, to the end that we shall not be compelled to work with any lay controlled system of medical practice.

Those of our confreres who have returned from the armed services we hope will put every effort behind our fight to preserve with as little change as possible the method of practice they left behind when they entered the services of our country.

Respectfully submitted,
Edwin L. Bruck, *Councilor-at-Large.*

To the President and the House of Delegates:

The past year has been one filled with serious problems to which the council has given long and careful consideration. It has been my privilege to be present at these deliberations and to take an active part in keeping the men in my local community informed.

Respectfully submitted,
Edward B. Dewey, *Councilor-at-Large.*

To the President and the House of Delegates:

As one of your Councilors-at-Large, I have regularly attended the meetings of the Council during the past year, and have been gratified to note the courageous and at the same time wise manner in which the officers of the Association have dealt with current problems. I have accepted committee appointments as they were offered and have attempted to be conscientious in attending the committee meetings, especially the so-called Chandler Committee, for the study of prepaid medical care. It is my belief that the deliberations of this Committee will prove not only enlightening to the Committee members themselves but valuable over the long pull for the California Medical Association at large.

Respectfully submitted,
Sidney J. Shipman, *Councilor-at-Large.*

To the President and the House of Delegates:

As one of your Councilors-at-Large I have attended all regular and special meetings of the Council during the year; have visited a number of the component societies in the first district; and supported the activity of all organized groups of the district.

Respectfully submitted,
Walter S. Cherry, *Councilor-at-Large.*

To the President and the House of Delegates:

I have attended all the meetings of the Council and the House of Delegates and have engaged in all the deliberations and actions of both bodies. The ever present problems of compulsory health insurance and the California Physicians' Service have been the outstanding issues of this year. The progress that has been made in the general all around picture of the California Physicians' Service and the concerted effort of organized medicine to push the widespread use of the voluntary prepaid plan of medical care makes the bogey of socialized medicine seem a little further removed than at this time last year.

Respectfully submitted,
E. Earl Moody, *Councilor-at-Large.*

To the President and the House of Delegates:

The past year has presented many important problems for consideration, especially in the field of public relations and legislative activities.

As a member of the council, it has been my aim to contribute constructively to the various discussions to the end that organized medicine in California be directed in a logical long term program for the better medical care of the people of this State, and at the same time safeguard and strengthen the rights and privileges of private practice.

I am retiring from the council this May after six years of service, and while I give full credit to the able and unselfish service rendered by my fellow councilors I cannot refrain from expressing my conviction that there should be an unwritten law if not a constitutional amendment limiting the service of any one councilor to two consecutive three-year terms.

Surely six years should give any man full opportunity to express himself and to contribute what he has to offer. Then by withdrawing he can well continue his effective work in educating and informing his local associates while the democratic form of our organization is maintained in actual operation by the election of new blood to the council.

Dewey R. Powell, *Councilor-at-Large.*

REPORTS OF COMMITTEES

EXECUTIVE COMMITTEE

Executive Group

John W. Cline, Chairman
Philip K. Gilman, President
Sam J. McClendon, President-Elect
E. Vincent Askey, Speaker, House of Delegates
Philip K. Gilman, Chairman of the Council
John W. Cline, Chairman, Auditing Committee
George H. Kress, Secretary-Treasurer and Editor

To the President and the House of Delegates:

The Executive Committee has met in part or in whole nine times during the past year. In the intervals between Council meetings, it has transacted important business for the Council. When only a portion of the membership was present, the remaining members have been informed of actions by mail and their opinions and votes solicited.

All acts of the Executive Committee have been reviewed by the Council, and these actions and their approval have been published in the minutes of the Council.

Respectfully submitted,
John W. Cline, *Chairman.*

AUDITING COMMITTEE

Executive Group

John W. Cline, Chairman, 1946
Edwin L. Bruck, 1946 Lloyd E. Kindall, 1946

To the President and the House of Delegates:

The Auditing Committee has performed the functions laid down in the by-laws. The professional audit of the Association books showed them to have been accurately kept, and the Committee has submitted its recommendations for the 1947 budget.

The Committee recommended to the Council that the fiscal year of the California Medical Association be changed to date from July first instead of January first and the Council in turn has recommended this change to the House of Delegates.

Respectfully submitted,
John W. Cline, *Chairman.*

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Executive Group

Dwight H. Murray, Chairman, 1947
Edmund T. Remmen, 1946 Lloyd E. Kindall, 1948
Philip K. Gilman, President, ex officio
Sam J. McClendon, President-Elect, ex officio

To the President and the House of Delegates:

The 1945 legislative session was one of the busiest ever experienced by the medical profession. During the closing days of the session an attempt was made to pass a Bill for Compulsory Hospitalization. There were two interim committees appointed, one consisting of seven men was appointed by the Assembly, and one consisting of five men appointed by the Senate. Each committee was to study the entire question of compulsory health insurance and make separate reports by June, 1946.

The regular session of the Legislature having adjourned the latter part of June left only a six months' recess until a special session was called on January 7, 1946.

At this session particular consideration was given to Senate Bill 40 which had the endorsement of the Administration, C.I.O., A.F.L., and many others. This Bill was for sickness disability, that is, the unemployed who were ill might draw disability benefits for a total of 35 weeks at a maximum of $20.00 weekly. This Bill, with some amendments was passed by the Legislature, signed by Governor Warren, and is now a law.

Also at this special session, we opposed the FEPC legislation which was decisively defeated.

Respectfully submitted,
D. H. Murray, *Chairman.*

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Executive Group

John V. Barrow, Chairman, 1946
Anthony B. Diepenbrock, 1947 Edward F. Nippert, 1948

To the President and the House of Delegates:

The Committee on Associated Societies and Technical Groups has worked this year in about the same manner as in other years.

We feel we have been of some help to the Nurses Association and in part, to the Council of the State Board of Nurses Examiners. Much work was done in trying to aid in the Housing problem for the Nurses Schools, of which there are forty-one in the State.

We have suggested to the State Association that the State program have a member of the Nurses Association present the magnitude of their problems to the Doctors of the State.

With nearly fifty thousand nurses registered in the State of California, we are yet unable to supply the full quota of service to the hospitals and the public.

This problem should not be left entirely alone to the Nurses Association. They have done wonderful work and are building up the efficiency of the Nurses Schools to the highest standard that the State of California has ever seen. They need the assistance of every doctor in the State.

Each member of the committee has taken care of local community needs as his opportunity afforded. Other technical groups have made no call on the committee and have afforded no opportunity for helping them.

Respectfully submitted,
John V. Barrow, *Chairman.*

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Executive Group

J. C. Geiger, Chairman, 1946
E. Earl Moody, 1947 C. M. Burchfiel, 1948

To the President and the House of Delegates:

Your Committee on Health and Public Instruction has kept in touch with public health activities. In promotion of proposed improvements in rural health service, letters have been sent to component county societies, and to agricultural groups. The rural medical service problems are now receiving increased and active attention by national and regional committees of the A.M.A.

Respectfully submitted,
J. C. Geiger, *Chairman.*

COMMITTEE ON HISTORY AND OBITUARIES

Executive Group

Morton R. Gibbons, Sr., Chairman, 1947
Hyman Miller, 1936 Robert A. Peers, 1948
George H. Kress, ex officio

To the President and the House of Delegates:

California Medical Association, founded almost 100 years ago, in 1856, now having a membership in excess of 7,000, making it the third largest state medical association in the United States, and with a glorious record in public health and other achievement, is unfortunate in that no history of the organization has ever been compiled or published.

This sad fact has been a source of regret to those physician members of the present day who hold that a knowledge of the worthy accomplishments of leaders who carried on the work in former years makes for increased and successful endeavor by those who at the present time must carry on.

It is a source of gratification to the Committee on History to call attention to the recent action of the Council of the California Medical Association in electing to the position of Honorary Historian, the retiring Secretary-Editor, Doctor George H. Kress. Because of his official connection with the California Medical Association since the year 1905, and because of his interest in Californiana, it is believed by your committee that the collection of memorabilia and the compilation and preparatoin of the same for use in an historical volume will now have a fair chance of realization. The Committee on History will be glad to lend all possible aid in the work.

To permit historical investigations and compilations to be carried on in efficient manner, the Committee on History suggests that the Association budget might well contain an allocation for necessary clerical and other needs.

Appended to this report appears a list of those of our

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THEY DIED FOR US

Members of California Medical Association Who Died While in Service During World War II

Altman, Allen A. (Lieut.) U.S.A.—4-11-43
Baxter, Clarence Pennell (Lieut. Col.) U.S.A., 4-27-43
Briggs, Wallace R. (Lt. Comdr.) U.S.N., 12-18-44
Brumbaugh, Donald H. (Comdr.) U.S.N., 5-4-41
Caldwell, Jay H. (1st Lieut.) U.S.A.—2-27-43
Campbell, Henry S. (Major) U.S.A.—7-7-45
Curtin, Edward D. (Lieut. j.g.) U.S.N.—3-27-44
Davis, William Dewey (Captain) U.S.A.—4-28-45
Dillon, Joseph, Jr. (Lieut. s.g.) U.S.N.—12-6-42
Fesca, Helmut W. (1st Lieut.) U.S.A.—7-27-44
Gafford, James A. (Lieut.) U.S.N.—5-4-45
Gidley, Donald S. (Major) U.S.A.—6-5-42
James, Lloyd B. (Captain) U.S.A.—7-3-45
Keltz, Charles (Captain) U.S.A.—10-24-44
Konigsberg, Jerome (Captain) U.S.A.—2-4-44
Kramer, Lowell Graft (Comdr.) U.S.M.—Date of death unknown
Lennon, Thomas J. (Major) U.S.A.—11-12-44
Liljencrantz, Eric (Comdr.) U.S.N.—12-6-42
MacMillan, John Kerr (Captain) U.S.A.—10-5-45
MacPherson, William (Captain) U.S.A.—4-28-45
Miller, George B. (Lieut.) U.S.A.—7-14-44
Moore, John Wesley (Captain) U.S.A.—3-10-44
Neubert, Albert D. (Major) U.S.A.—10-29-43
Nolan, Oscar F. (Lieut. Col.) U.S.A.—11-12-44
Porporato, Albert J. (Lieut.) U.S.N.—4-28-45
Rethers, Charles A. (Lieut.) U.S.N.—5-26-43
Rhodes, George K. (Colonel) U.S.A.—7-23-44
Steele, Warren N., Jr. (Captain) U.S.A. Air Corps—10-23-43
Sullivan, James M. (Colonel) U.S.A.—1-31-45
Vincent, Ward R. (Lieut. j.g.) U. S. Marines—Oct., 1943
West, Jesse H. (Captain) U.S.A.—2-4-45
White, Alfred S. (Lieut. Col.) U.S.A.—2-13-46
Wisser, Leonard O. (Major) U.S.A.—11-17-45
Young, Dwight Dunham (Comdr.) U.S.M.—May, 1945

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In Memoriam

Alameda County

Benjamin Warren Black (December 1, 1945)
George Ballantyne Brown (March 1, 1945)
George Vrooman Cochran (July 2, 1945)
Frederick William Hodgkins (April 6, 1945)
Fred Porter Nevius (June 14, 1945)
Sidney Nuttall Parkinson (October 31, 1945)
Lillian Sields (March 22, 1945)
Charles Henry Zander (June 16, 1945)

Colusa County

George Washington Desrosier (October 25, 1945)

Fresno County

Harold John Cooper (November 5, 1945)
Angus Bertrum Cowan (April 20, 1945)
Lloyd Bertram James (July 3, 1945)
Carl Henry Shuck (November 11, 1945)

Humboldt County

Lowell Graft Kramar (killed in action, U.S.N.)

Kern County

Jesse Headen Inman (July 1, 1945)

Los Angeles County

Albert Harold Aland (July 24, 1945)
James T. M. Allan (August 26, 1945)
Joseph T. Axline (August 14, 1945)
Richard Wortman Baker (August 8, 1945)
Horace Russell Boyer (November 10, 1945)
Ctimir Sclas Brazda (December 8, 1945)
Carl Gottlieb Bretthauer (September 21, 1945)
Miles John Breuer (October 14, 1945)
Mackall R. Bruin (March 10, 1945)
Annie Sophia Bullock (December 7, 1945)
Henry Sutherland Campbell (July 7, 1945)
Howard Russell Cooder (March 26, 1945)
William Dewey Davis (April 28, 1945)
Camilles Ogden Driver (August 2, 1945)
Newton Gurdon Evans (December 19, 1945)
Kendal Frost (September 26, 1945)
James Albert Gafford, Jr. (killed in action, U.S.N.)
Carl Victor Green, Jr. (December 18, 1945)
Josephine Agnes Jackson (December 31, 1945)
Joseph Warren Johnson (November 12, 1945)
Charles Keltz (October 24, 1945)
Kalim Basil Khuri (November 4, 1945)
Robert Ward Lamson (December 31, 1945)
Alonzo E. Mack (November 20, 1945)
William Lewis Colquhoun MacBeth (Mar. 1, 1945)
John Kerr MacMillan (October 15, 1945)
William Alexander MacPherson (April 28, 1945)
Ernst Valentine Neumann (September 14, 1945)
Charles Eaton Phillips (June 15, 1945)
Lawrence Alexis Sagnella (October 29, 1945)
Joseph Shnearer (September 25, 1945)
Bertrand Smith (January 23, 1945)
Rogers Fairbanks Wakefield (September 3, 1945)
Emmet Leroy Wemple (February 10, 1945)

Mendocino County

Fletcher Jackson Van Meter (August 4, 1945)

Monterey County

James Harvey Clark (December 11, 1945)
Gustave Herman Taubles (January 24, 1945)
Walter Leon Teaby (May 2, 1945)

Orange County

Dean Cassius Brown (February 24, 1945)
Frederick William Weston (December 1, 1945)
Dwight Dunham Young (May, 1945)

Riverside County

Leon Mitchell Wilbor (December 5, 1945)

Sacramento County

Edward Saunders Babcock, Jr. (Sept. 3, 1945)
Beaumont Brown (July 2, 1945)

San Bernardino County

Frank Farnum Abbott (March 9, 1945)
Donald Harmon Brumbaugh (killed in action, U.S.N.)
Stephen Adelbert Craig (June 26, 1945)

San Diego County

Thomas Maltby Cunningham (February 26, 1945)
William Russell Eastman (December 28, 1945)
Charles Summers Marsden (October 13, 1945)
Lester Mills Stearns (January 4, 1945)

San Francisco County

Lloyd Bryan (December 21, 1945)
John McGrath Collins (September 2, 1945)
Helmut William Fesca (killed in action, A.U.S.)
Martin Icove Green (June 30, 1945)
Arthur Proschold Kaelber (September 6, 1945)
Pearl Elizabeth Koch (April 7, 1945)
Clara Lydia Kohls (March 18, 1945)
Frank Worthington Lynch (January 14, 1945)
John Harold Mansfeldt (October 4, 1945)
Albert Brown McKee (August 19, 1945)
John McQuade (November 17, 1945)
Albert John Porporato (April 28, 1945)
James Fowler Pressley (May 25, 1945)
Herman Joseph Schlageter (January 19, 1945)
Kenneth Clark Strong (July 3, 1945)
James McGeough Sullivan (January, 1945)
David Armstrong Taylor (January 2, 1945)
Helen Jane Waterman (October 14, 1945)
Jesse H. West (February 4, 1945)

San Joaquin County

John Dysart Dameron (September 25, 1945)
Hunter Lee Gregory (November 10, 1945)
John Madison Hench (May 7, 1945)
Boyd Merrill Krout (May 4, 1945)
John James Tully (June 4, 1945)

San Mateo County

John Nelson Blood (December 26, 1945)
Robert Fisher Monteith (April 10, 1945)

Santa Barbara County

Albert Joseph Holzman (August 21, 1945)
Edgar Paul Murdock (June 24, 1945)
Edgar Daniel Smith (August 15, 1945)

Santa Clara County

Adolph John Baiocchi (February 16, 1945)
Frederick Christian Garlach (October 4, 1945)
Michael William Kapp (June 12, 1945)

Sonoma County

Henry Stanley Rogers (September 14, 1945)

Stanislaus County

Leonard Otto Wissner (November 17, 1945)

Yolo County

Chester Hyman Fairchild (September 6, 1945)

members whom Divine Providence has seen fit to take from our midst during the year 1945.

Colleagues who were in the Armed Forces, and who were killed in action are listed in a separate group.—They Died for Their Country.

Respectfully submitted,
Morton R. Gibbons, Sr., *Chairman.*

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Executive Group

Clarence E. Rees, Chairman, 1948
Benjamin W. Black, 1946* Ray E. Thomas, 1947

To the President and the House of Delegates:

A meeting of this committee has not been called during the current year. No problems have been presented by the Council, the House of Delegates, or the membership of the Society.

This committee stands ready to coöperate in every way should any problems arise or should its advice be requested.

Respectfully submitted,
Clarence E. Rees, *Chairman.*

COMMITTEE ON INDUSTRIAL PRACTICE

Executive Group

Donald Cass, Chairman, 1948
Carl L. Hoag, 1946 N. P. Dunne, 1947

To the President and the House of Delegates:

Your Committee on Industrial Practice has had no meetings during the year. The problems of industrial medicine and surgery are increasing in importance as the years go by, and the industrial doctor becomes more and more a specialist.

Our standing committee on industrial medicine has had no problems. The only pending question before the committee has been the request of increase in fee schedule. As you know, this is being handled entirely by our special committee, headed by our legal staff for the California Medical Association.

Respectfully submitted,
Donald Cass, *Chairman.*

COMMITTEE ON MEDICAL ECONOMICS

Executive Group

H. Gordon MacLean, Chairman, 1948
Howard W. Bosworth, 1946 Wayne J. Pollock, 1947

To the President and the House of Delegates:

The chairman of the Committee on Medical Economics met with the president of the California Medical Association and several members of the Executive Committee during the year and discussed the advisability of this committee initiating efforts to determine the type of prepaid medical insurance the doctors of the California Medical Association would sponsor and fully back. It was decided that the Interim Committee of the California Medical Association, for the study of medical care plans, under the chairmanship of Dean L. R. Chandler, would study this subject, therefore this committee took no further action. No further matters were referred to the committee by the Council.

Respectfully submitted,
H. Gordon MacLean, *Chairman.*

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Executive Group

B. O. Raulston, Chairman, 1947
William J. Kerr, 1946 L. R. Chandler, 1948

To the President and the House of Delegates:

Following termination of the war, medical education has been affected in these respects:

1. The Navy terminated its program for support of medical students in December, 1945.

2. The Army is to terminate its program for the support of all but Senior medical students in March, 1946.

3. Medical Schools will, with few if any exceptions, return to the teaching programs that were in effect before 1941.

4. Premedical students between the ages of 18 and 26 years are not to be deferred from Military Service if they are physically fit. The Freshman classes to be admitted in the autumn of 1946 must be selected from veterans, those physically disqualified for military service and women.

One item in the accelerated program for Medical Schools was an increase of from 20 to 25 per cent in the number of students in each class. What the future policy of the various schools will be in regard to this phase of acceleration is undetermined. If the various government services are to require much larger numbers of medical officers than they used before the war, perhaps the larger classes in Medical Schools may be counted upon to offset the removal of these men from civilian practice.

An extremely important and difficult task for all Medical Schools is an attempt to meet the demands of veteran doctors for additional professional training as they return from Military Service. Each of the four schools in California is providing increased numbers of residencies and offering a variety of graduate courses. It is impossible to accommodate all who apply, but a strenuous effort is being made and an ever increasing number of possibilities are being offered. There are definite indications that the demand for this type of training will continue indefinitely. It is a challenge to the Medical Schools and it must be met as completely as possible.

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* Deceased.

The proposed changes announced by the Veterans' Administration will provide improved medical care for the patients and also a large number of residencies. This program will be of great value in the training of young doctors who have returned from military service.

Respectfully submitted,
B. O. Raulston, *Chairman.*

COMMITTEE ON MEDICAL DEFENSE

Executive Group

Nelson J. Howard, Chairman, 1947
Louis J. Regan, 1946 William A. Key, 1948

To the President and the House of Delegates:

The replies from the different State medical associations, in response to questionnaire on malpractice insurance sent out by John Hunton, Executive Secretary, have not been sufficiently studied or compared, as yet, to submit any recommendation to the State Association for their consideration.

Respectfully submitted,
Nelson J. Howard, *Chairman.*

COMMITTEE ON PUBLICATIONS

Executive Group

George W. Walker, Chairman, 1946
F. Burton Jones, 1947 R. H. Sundberg, 1948
George H. Kress, ex officio

To the President and the House of Delegates:

It has been difficult in the past years, because of government restrictions, to find space to publish all that should have been published. Extra demands brought on by essential wartime articles have crowded other meritorious material, but every effort possible has been made to publish all for which room could be found.

Respectfully submitted,
George W. Walker, *Chairman.*

COMMITTEE ON POSTGRADUATE ACTIVITIES

Executive Group

F. E. Clough, Chairman, 1946
H. F. Freidell, 1947 John C. Ruddock, 1948
George H. Kress, Secretary, ex-officio

To the President and the House of Delegates:

It was not possible in 1945 to present to the county medical societies, programs for postgraduate conferences. With the large number of C.M.A. members who were in military service, and the stress and strain under which civilian members were working, many of the component county societies found it difficult to carry on meeting routines, such as existed during pre-war years.

However, working in coöperation with the Wartime Graduate Medical Meetings committee, it was possible to present programs in military hospitals and adjacent centers.

An effort was also made to promote the use of medical films, a number of which were purchased by the California Medical Association, for use through the Committee on Postgraduate Activities. Unfortunately, during the last five years, very few new medical films were produced, on which account the films that were purchased needed supplementary comment by members, in order to bring out advances in procedure that had come to the front during the war years.

During the next few years a large number of up-to-date medical films on sound reels will be produced. It is to be hoped that it will be possible to promote the purchase and use of such, because experience has shown that a good twenty to thirty minute film can add much to the interest of a meeting, thus making for better attendance in many county societies and more interesting county society meetings.

Under existing conditions, the functions of the Committee fell in good part on the shoulders of the Association Secretary, Dr. Kress, who as the committee secretary, and as editor of CALIFORNIA AND WESTERN MEDICINE, carried on the Committee's work.

Respectfully submitted,
F. E. Clough, *Chairman.*

COMMITTEE ON PUBLIC RELATIONS

Executive Group

John Hunton, Director

To the President and the House of Delegates:

All public relations activities for 1945 were turned over, by action of the Council, to a professional public relations firm. This concern is still operating on behalf of the Association under terms and budget arrangements approved by the Council, with emphasis on the spreading of public knowledge concerning the voluntary systems of health insurance.

Under these arrangements, the Department of Public Relations of the Association has not been active during 1945.

Respectfully submitted,
John Hunton, *Director.*

COMMITTEE ON SCIENTIFIC WORK

Executive Group

George H. Kress, Chairman, ex-officio
Fletcher B. Taylor, 1946 J. Homer Woolsey, 1947
Howard F. West, 1948
Francis L. Chamberlain, ex-officio (for Medicine)
Eugene J. Joergenson, ex-officio (for Surgery)
(In coöperation with Officers of Scientific Sections)

To the President and the House of Delegates:

During the last several years it has been necessary for the California Medical Association to limit itself to two-day streamlined Saturday-Monday annual sessions.

This year the Association returns to its former practice of four-day sessions such as were held for years at Hotel Del Monte in Monterey County.

Unfortunately the Association is now faced with the condition that hotel facilities for thirteen Scientific Sections and four accessory bodies are practically not available in California. Therefore, it has been necessary to return again to the Hotel Biltmore in Los Angeles, even though that hotel has been obliged to place a limit on the use of the facilities of its conference rooms, owing to standing and prior commitments.

This year, the work of the Section Officers has been made more difficult because of the transition from two- to four-day meetings; and also because of the large number of C.M.A. members still attached to the military services, and the extent to which colleagues in civilian practice have had their time encroached upon through larger professional responsibilities, with less time for research studies.

In spite of the above and other handicaps, it is hoped that programs have been drafted that will have appeal and value to C.M.A. members who will be present.

The thanks of the central C.M.A. Committee are extended to all Section Officers who have coöperated in arranging the programs. The indulgence of attending members is asked for meeting room or other deficiencies that may arise during the meeting. It can only be said that efforts were made to reduce these to a minimum.

Respectfully submitted,
George H. Kress, *Chairman.*

EDITORIAL BOARD: CALIFORNIA WESTERN MEDICINE

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L. Dale Huffman, Hollywood
Mast Wolfson, Monterey
General Surgery (including Orthopedics):
Frederic C. Bost, San Francisco
Fred D. Heegler, Napa
William P. Kroger, Los Angeles
Industrial Medicine and Surgery:
John D. Gillis, Los Angeles
John E. Kirkpatrick, San Francisco
Plastic Surgery:
William S. Kiskadden, Los Angeles
George W. Pierce, San Francisco
Neuropsychiatry:
Olga Bridgman, San Francisco
John B. Doyle, Los Angeles
Obstetrics and Gynecology:
Daniel G. Morton, San Francisco
Donald G. Tollefson, Los Angeles
Pediatrics:
William W. Belford, San Diego
William C. Deamer, San Francisco
Pathology and Bacteriology:
Alvin G. Foord, Pasadena
R. J. Pickard, San Diego
Radiology:
John W. Crossan, Los Angeles
R. R. Newell, San Francisco
Urology:
Frank Hinman, San Francisco
Albert J. Scholl, Los Angeles
Pharmacology:
W. C. Cutting, Menlo Park
Clinton H. Thienes, Los Angeles

To the President and the House of Delegates:

Thanks are hereby given to the members of the Board for their valuable assistance and ideas.

All issues of our Journal have been well filled. State Association activities fill approximately one-third of the available pages. In addition to this, many excellent articles have been published, space being found for most of the desirable contributions.

The editorial columns have brought before our members many important subjects such as the Compulsory Sickness Insurance Law for California, the Wagner-Murray Social Security Amendment and Postwar Educational Facilities for Military Colleagues.

The editorial office is to be commended for the completeness of our Journal and the promptness in which it is published and delivered. This is quite remarkable at a time when most foreign journals have suspended publication and many of our national journals are not only markedly reduced in size but also are from two to four months behind their scheduled appearance time.

As this report is sent forward, we learn that Dr. George H. Kress, who for so many years has been editor of California and Western Medicine, now having reached retirement age, will relinquish his editorial duties to become the Honorary Historian of the California Medical Association. We wish to express to him our appreciation of the cordial coöperation he has given to the Editorial Board, and to extend good wishes as he takes on the important work of gathering material for a history of the California Medical Association.

Respectfully submitted,
Albert J. Scholl, *Chairman.*

COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

* * *

PROCUREMENT AND ASSIGNMENT SERVICE

Executive Group
Harold A. Fletcher, San Francisco
Chairman for Northern California
William H. Kiger, Los Angeles
Chairman for Southern California

To the President and the House of Delegates:

The work of the Procurement and Assignment Service during the past year has been mostly concerned with the relocation of returning veteran doctors to their previous locations and the locating of new physicians from out of state in localities where their services were needed. After the defeat of Germany, and more so after the defeat of Japan, the Procurement and Assignment Service was deluged with a tremendous number of requests for information regarding locations available in California. It was readily seen that if such physicians were not located in places which needed them and concentrated in areas already adequately covered, it would not only work a great hardship on veteran physicians returning to their old locations, but would also deplete a great many out-of-state areas already understaffed with physicians. Procurement and Assignment Service, therefore, issued a directive to its county committees outlining the methods and policies to be followed in the classification of physicians locating in their areas. The publicity in the various medical journals which was given this program served the purpose of retarding the flow of out-of-state physicians into California, and in retarding the movement from one county to another in California during the rapid demobilization period. In February, 1946, the Procurement and Assignment Service was instructed to discontinue all further classification of physicians, this work was discontinued.

The remaining part of the program of the Procurement and Assignment Service had been mostly the carrying out of the directives concerning interns and residents in approved hospitals. This work is almost completed as after April 1, 1946, the 9-9-9 program will be discontinued for interns and residents, and after July 1, 1946, there will be no further quotas allocated to approved hospitals. Interns who were appointed for the nine months ending April 1, 1946, are allowed to continue for another three months to July 1. All residents whose appointments end on April 1 and who hold reserve commissions will be called to active duty and will be replaced to a great extent by young veterans returning from active duty who need and wish further hospital training.

Respectfully submitted,
Harold A. Fletcher, *Chairman.*

COMMITTEE ON LOCAL ARRANGEMENTS

Executive Group
E. T. Remmen, Chairman
L. A. Alesen
Louis J. Regan
W. H. Geistweit, Jr.
Arthur E. Varden
George H. Kress, ex-officio
S. K. Cochems, ex-officio

To the President and the House of Delegates:

The greatest difficulty faced by the Committee on Local Arrangements this year was the securing of ample hotel accommodations for members attending the annual session. Because of postwar congestion in Los Angeles, hotels with the exception of a very few, were loath to set aside any large number of rooms. A number of hotels refused to coöperate. Appreciation is expressed to those hotel managers who did assist to the best of their ability.

The responsibility of attempting to provide accommodations was placed on the office of the Los Angeles County Medical Association and was accepted. Every hotel that could offer acceptable housing facilities was contacted. Reservations were made through the office of the Association and a system used to avoid misunderstandings. The doctor obtaining a reservation received a card from the Association stating exactly what his reservation was. A duplicate of this card was sent to the hotel at which the reservation was made, and a triplicate card was retained at the office of the Los Angeles County Medical Association.

Respectfully submitted,
E. T. Remmen, *Chairman.*

COMMITTEE ON PHYSICIANS' BENEVOLENCE

Executive Group

Axcel E. Anderson, Chairman
Robert A. Peers Elizabeth Mason-Hohl

To the President and the House of Delegates:

During the calendar year 1945, receipts for the fund were $5,604.00 from the California Medical Association, plus $50 interest, plus $1,146.67 from the Woman's Auxiliary to the California Medical Association; making a total of $6,800.47. Disbursements amounted to $4,600.00. Our disbursements to the Los Angeles County Physicians' Aid Association were increased to $500 per month. One needy old doctor in Fresno County is receiving $25 per month. We are, of course, providing only a little help. Our ideal of decent and complete care of our own is a future objective that it is hoped will be realized. The Los Angeles County Physicians' Aid Association has offered to coöperate with the C.M.A. to provide a center for the housing and complete care of our needy. Good progress has been made. But substantial contributions will be required to realize the goal of $500,000 deemed necessary. About $160,000 of this amount has already been subscribed. Donations for this fund are deductible for income tax returns. Bequests and subscriptions for this fund are approved charity, and is recommended for the consideration of all C.M.A. members.

Respectfully submitted,
Axcel E. Anderson, *Chairman.*

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

Executive Group

Carl L. Mulfinger, Chairman, 1947
L. H. Redelings, 1946 Harold G. Trimble, 1948

To the President and the House of Delegates:

The Committee on Organization and Membership of the California Medical Association hereby begs to make its report for the year 1945. There is appended a summary of the C.M.A. County Society memberships for the year 1945 as compiled by our central office. An increase in membership of the entire organization is to be noted. As there is a decrease of military members day by day, this present data will be somewhat obsolete.

All the component county societies have been making a special effort to reinstate their war veteran society members in their former practices. Of necessity this report is too brief to go into detail regarding the methods of aid for returning veterans. In order to acquaint the new members of the County and State Society with the history, traditions, and obligations, an indoctrination program was recently instituted by the Los Angeles County Medical Society which has as its object the betterment of professional relations within the group, and a comprehensive knowledge of the County and State Association.

Respectfully submitted,
Carl L. Mulfinger, *Chairman.*

* * *

C.M.A. County Society Membership Totals for Calendar Year 1945

County Medical Societies	*Membership in 1944*	*Number Licensed Physicians (1945 State Directory)* (C.M.A. and non-C.M.A.)*	*Civilian C.M.A. Members in 1945*	*Military C.M.A. Members in 1945*	*Total C.M.A. Members 1945*
Alameda	636	711	543	127	670
Butte-Glenn	36	35	28	10	38
Contra Costa	68	99	67	6	73
Fresno	156	133	120	37	157
Humboldt	36	34	25	11	36
Imperial	25	21	14	11	25
Inyo-Mono	12	13	7	4	11
Kern	78	86	59	20	79
Kings	23	20	15	8	23
Lassen-Plumas-Modoc	20	18	10	6	16
Los Angeles	3,095	4,014	2,609	638	3,247
Marin	52	64	41	13	54
Mendocino-Lake	28	35	17	10	27
Merced	30	19	19	14	33
Monterey	75	78	55	18	73
Napa	41	50	32	8	40
Orange	135	136	98	39	137
Placer-Nevada-Sierra	38	36	28	9	37
Riverside	79	101	66	11	77
Sacramento	178	155	151	32	183
San Benito	7	9	5	2	7
San Bernardino	183	177	143	41	184
San Diego	367	431	267	114	381
San Francisco	1,197	1,404	918	324	1,242
San Joaquin	110	92	78	34	112
San Luis Obispo	30	31	24	5	29
San Mateo	98	113	82	22	104
Santa Barbara	128	109	87	41	128
Santa Clara	233	216	181	61	242
Santa Cruz	45	40	36	11	47
Shasta	26	17	14	8	22
Siskiyou	14	17	10	2	12
Solano	49	71	48	5	53
Sonoma	73	80	56	20	76
Stanislaus	56	48	38	18	56
Tehama	8	11	7	1	8
Tulare	56	59	41	16	57
Ventura	52	55	38	20	58
Yolo	27	17	24	3	27
Yuba-Sutter-Colusa	27	23	20	9	29
Total	7,627	8,878	6,121	1,789	7,910

* Note. The numbers of licensed physicians under the respective counties are those which appear in such listings in the 1945 Directory of the State Board of Medical Examiners. The State Board of Medical Examiners does not list in the county rosters the names of licensed physicians who are in military service. These are listed in the alphabetical index which commences on page 51 of the 1945 Directory, the name of each such military member being marked by a star.

CANCER COMMISSION

Executive Group

Lyell C. Kinney, Chairman, 1946
Whitfield Crane, Vice-Chairman, 1947
Orville N. Meland, Secretary, Southern California, 1946
David A. Wood, Secretary, Northern California, 1948
Harold Brunn, 1946 Gertrude Moore, 1947
George Sharp, 1947 Henry J. Ullmann, 1948
James F. Rinehart, 1948

To the President and the House of Delegates:

On May 7, 1945, the House of Delegates referred the question of "Prevention Clinics" to the Cancer Commission for further study and early report to the Council. That study has been made and the report has been submitted to the Council. During the year, at the direction of the Council, the members of the Cancer Commission have acted as members of the State Executive Committee of the American Cancer Society. With the help of Mr. H. Hassard an effort has been made to make a compact business organization and articles of incorporation have been drawn up to place the work in California on a permanent business basis.

On July 1st, Mrs. Helen Ingalls Ullmann retired as State Commander of the Field Army after five years of efficient, devoted service. The medical profession in California is greatly indebted to her for her effort to develop cancer control in this State and for her close coöperation with the California Medical Association.

The new Commander, Mrs. Doris Ryer Nixon, comes to the work of the Cancer Society thoroughly trained in organizational problems. She is intensely interested in the cancer control program, is giving generously of her time and is coöperating fully and efficiently with the representatives of the California Medical Association.

The Cancer Commission has arranged for a revision of the Cancer Commission Studies of 1934. This will be developed along the lines of the Cancer Manuals published by Massachusetts, Iowa and Michigan and the work should be ready for distribution during the current year.

With the return of the men from military service it is possible to reopen the pre-convention conferences under the direction of the Cancer Commission. The conference on Radiology and the conference on Pathology will be held this year on the day preceding the annual meeting.

The principal work of the Cancer Commission, i.e., that of supporting and organizing approved cancer clinics in general hospitals and of postgraduate education of physicians in cancer, is developing slowly, but the Commission expects to press this program during the coming year.

Respectfully submitted,
Lyell C. Kinney, *Chairman.*

CALIFORNIA PHYSICIANS' SERVICE

Executive Group

Board of Trustees
Lowell S. Goin, M.D., President, Los Angeles
A. E. Moore, M.D., Vice-President, San Diego
H. Randall Madeley, M.D., Vice-President, Vallejo
Chester L. Cooley, M.D., Secretary, San Francisco
Donald D. Lum, M.D., Assistant Secretary-Treasurer, Alameda
C. Glenn Curtis, M.D., Brea
J. Frank Doughty, M.D., Tracy
P. K. Gilman, M.D., San Francisco
C. L. Mulfinger, M.D., Los Angeles
Rt. Rev. Thomas J. O'Dwyer, Los Angeles

* * *

Executive Staff
W. M. Bowman, Executive Director
A. E. Larsen, M.D., Medical Director
W. H. Gardenier, M.D., Assistant Medical Director

To the President and the House of Delegates:

This report on the activities of the California Physicians' Service for the year 1945 must necessarily be shorter than usual since the final reports are not available at this time. A final report will be reported at the House of Delegates Meeting in May, 1946.

REORGANIZATION

At the meeting of the new Board of Trustees in May, 1945, in Los Angeles, Mr. William M. Bowman was chosen as the Executive Director of the California Physicians' Service. Mr. Bowman was chosen after the committee had searched for one year for an Executive Director. He has ably reorganized the California Physicians' Service business structure and has more than fulfilled our hopes as a business executive. He has made many changes in personnel and also in business procedures. These changes have resulted in a marked increase in efficiency of the organization. Dr. Larson has remained as Medical Director in the North and Dr. Gardenier as Medical Director in the South.

NEW PAYMENT SYSTEM

Soon after Mr. Bowman took charge, he realized that the financial situation of the California Physicians' Service was not satisfactory. One of the reasons that the financial situation had occurred was caused by doctors being late in submitting their bills, thereby forming a hidden liability. The Board of Trustees have ruled that all physicians must have their bills presented to the California Physicians' Service within ninety days after completion of the case. In August, 1945, the unit value was dropped from $2.25 to $2.00. This procedure was recommended by Mr. Bowman since the increase in rates for the membership had not been fully in effect, would not be fully in effect for at least nine more months. At the present time the increase in rates are fully into effect and with the $2.00 unit value our financial condition was gradually improved so that the deficit of $279,144 as of October, 1945, has now been reduced to $137,912 as of May 1, 1946.

FEE SCHEDULE

The Fee Schedule committee has made a thorough study of the Fee Schedule of the California physicians during the past few months. There have been a few changes but with no definite lowering in rates. The fee on some procedures has been lowered while on others it has been raised. This will produce a redistribution of money at a more equal level.

RELATION WITH HOSPITAL ASSOCIATIONS

C.P.S. continues to write its own hospital service contract in Northern California and operate jointly with Hospital Service of Southern California, whereby, hospital contracts and medical service contracts are handled jointly. The Board of Trustees are aware of the importance of a Statewide hospital plan with one standard policy being developed in the very near future.

PROFESSIONAL MEMBERS

Throughout the year there has been a gradually increased number of professional members with California Physicians' Service, until at the present time we have over 6,500 professional members distributed throughout the State, whereby, we are now able to furnish medical service to any beneficiary member in any part of the State of California. Sacramento County now has ample professional members to furnish medical care in that vicinity. It has been particularly gratifying to see the eager response of most returning veterans to become professional members of California Physicians' Service.

BENEFICIARY MEMBERSHIP

There has been a gradual increase in the number of beneficiary members until at the present time there are about 202,192. This has been accomplished under most trying conditions. A large number of our beneficiary members were working in war plants. Immediately after V-Day many of these war plants closed down with large numbers of Beneficiary members dropping their policies. Then, shortly after this, a large number of strikes occurred and men were laid off, accordingly because of strikes, their membership necessarily lapsed and we lost large numbers of beneficiary members in this manner. However, many of them are returning as the strikes have been settled. Considering the rapid loss of memberships due to the closing of war plants and strikes, the acquisition of new members has gradually increased in spite of our loss, so that a slow and gradual growth has been made. As soon as employment problems are settled on a permanent basis, we expect a rapid increase in growth from our beneficiary members.

THE WAR HOUSING PROGRAM

This program as you will remember was developed as a war emergency to take care of these people in certain areas where physicians were not available. C.P.S. did a magnificent job in this and has been commended by the Procurement and Assignment and other government agencies. These programs are now closed and we have no further programs in operation.

RURAL PROGRAM

During the past year we have been able to negotiate with the State Grange where a large number of farmers will be able to acquire California Physicians' Service. The rural programs which have been conducted under the Farm Security Administration will gradually be absorbed under the State Grange program. In a very short time there will be no more rural program under the Farm Security Administration.

VETERANS' PROGRAM

On February 1, 1946, the Veterans' Administration of Washington, D. C., signed a contract with California Physicians' Service, whereby veterans with service connected disabilities could contact their own doctors in their own communities and receive treatment for service connected disabilities. C.P.S. will pay the doctor according to the regular C.P.S. schedule and will be reimbursed by the Veterans' Administration.

An enormous amount of credit must be given to Mr. Bowman and Dr. Larson for the efficient way this program has been worked out. It has been estimated that at the present time there are approximately 1,350,000 veterans in the State of California. It has been estimated that approximately 60 per cent of returning veterans are claiming war disability. C.P.S. is fortunate in having an efficient business organization setup ready to handle this tremendous increase in business. This plan is not on a prepaid basis, it is strictly a fee for service basis.

SUMMARY

During the past year, Mr. Bowman, as Executive Director, has made many important changes in C.P.S. These changes in personnel and business procedures markedly increased the efficiency of our organization. We are now ready to handle large volumes of beneficiary members and expect to gain them rapidly during the next year. C.P.S. has been invited to Montana and New Mexico during the past few months to aid them in setting up similar plans of medical service in their own states. This has been done without cost to C.P.S. and plans are now operating in New Mexico and Montana. Two other states have asked for similar aid and we expect to have similar organizations in those states within the very near future.

Our financial situation has improved steadily and faster than we had hoped. This improvement has been due to the increased dues and improvement in office procedures which resulted in reduced costs.

C.P.S. now is in the most healthy state it has been since its infancy. It is under the direction of an Executive Director who has shown fine executive ability in his direction of business and sales procedures and has C.P.S. on a sound, financial and actuarial basis. Although we are still faced with the threat of socialized medicine on a Federal level and possibly on a State level, C.P.S. is now in a better position than ever to combat this sort of legislation. C.P.S. has proven that it can furnish medical service to the lower income groups efficiently, at a low cost that these groups are able to pay.

The Board of Trustees are particularly gratified with the increased coöperation of the medical profession in making this plan work. The future of C.P.S. is now secure and we are equipped with actuarial data, statistics and business procedures, whereby, we may handle large numbers of beneficiary members.

C. L. Cooley, *Secretary.*

PROFESSIONAL ADVISORY COMMITTEE TO THE BUREAU OF VOCATIONAL REHABILITATION

Executive Group

John W. Cline, Chairman
J. B. Harris — Gertrude Moore
E. Vincent Askey — L. C. Kinney

To the President and the House of Delegates:

The Professional Advisory Committee of the Physical Restoration Program of the Bureau of Vocational Rehabilitation has again been increased in size.

The Advisory Committee has met once during the year, and individual members have coöperated with the Bureau in the establishment of satisfactory procedures and an equitable fee schedule.

Recently, Dr. Martin Karv of the State Department of Public Health has been appointed a full time physician in the service of the Bureau. Mr. H. D. Hicker, Chief of the Bureau, has continued the excellent coöperation with the Advisory Committee, which was favorably reported to you last year. Mr. J. R. Davidson has also been extremely coöperative. The addition of Dr. Karv to the staff should further the work of the Bureau and should materially assist in satisfactory adjustment of the problems of the medical profession.

Respectfully submitted,
John W. Cline, *Chairman.*

COMMITTEE ON E.M.I.C.

Executive Group

Karl L. Schaupp, Chairman

Northern Subdivision	*Southern Subdivision*
Karl L. Schaupp, Chairman	Donald G. Tollefson
Lawrence Jacobus	William B. Thompson
Mast Wolfson	B. O. Raulston
John W. Sherrick	Charles G. Curtis
	Sam J. McClendon

George H. Kress, Secretary, ex-officio

To the President and the House of Delegates:

Problems arising in connection with E.M.I.C. as administered by the Federal Children's Bureau of the United States Department of Labor through constituted State Agencies (in California, through the Bureau of Maternal and Child Welfare of the California State Department of Public Health) have been many, and at times distressing. CALIFORNIA AND WESTERN MEDICINE has given considerable space in discussions thereon.

Since the Federal funds available for E.M.I.C. work have been dispensed only with approval of the Federal Children's Bureau, it was necessary for State Agencies to conform to the Federal Children's Bureau rules and directives.

It is of interest to note that proposed and similar legislation in Congress (such as S.1318, by Senator Pepper) are closely related to the program as carried on through

E.M.I.C. It is desirable that the medical profession maintain an active interest in existing and proposed legislation related to maternal and child welfare.

Respectfully submitted,
George H. Kress, *Secretary.*

LIAISON REPRESENTATIVE TO CALIFORNIA VETERANS' COMMITTEE

To the President and the House of Delegates:

Due to the fact that the meetings of the California Veterans' Commission were held during business hours I have been unable to attend many of the committee meetings this year. However, I have kept in close touch with the activities of this Commission and especially with those functions which were directly or indirectly related to the practice of medicine.

The most important medical contribution to the activities of this Commission thus far has been the assistance given by those psychiatrists who served on local Community Veteran Affairs Committees. At the present time the rehabilitation of veterans is progressing rapidly and smoothly with active coöperation by the medical profession wherever necessary.

Respectfully submitted,
Frank A. MacDonald, *C.M.A. Representative.*

COMMITTEE ON POSTWAR PLANNING

Executive Group

Harold A. Fletcher, Chairman
B. O. Raulston, Chairman Southern California

L. R. Chandler
Benjamin W. Black*
Phoebus Berman
Wilton L. Halverson
A. B. Diepenbrock
Frank W. Otto

Philip K. Gilman
John W. Cline
John Hunton
W. T. Harrison
William P. Shepard
William H. Kiger

To the President and the House of Delegates:

The following is a report of the Committee on Postwar Planning:

The organization meeting of this committee was held at the Town House, Los Angeles, on May 7, 1945. The members appointed to serve were as follows:

L. R. Chandler, M.D., Dean, Stanford University School of Medicine, Clay and Webster Sts., San Francisco, Calif.

B. O. Raulston, M.D., Dean of the University of Southern California, Los Angeles, Calif.

Benjamin W. Black, M.D., Superintendent, Alameda County Hospitals, Oakland, Calif.

Phebus Berman, M.D., County Hospital, Los Angeles, Calif.

Wilton Halverson, M.D., Director, State Department of Public Health, 760 Market St., San Francisco, Calif.

A. B. Diepenbrock, M.D., 450 Sutter St., San Francisco, Calif.

Frank Otto, M.D., 3875 Wilshire Blvd., Los Angeles, Calif.

Philip K. Gilman, M.D., Chairman, Council of the California Medical Association, 450 Sutter St., San Francisco, Calif.

John W. Cline, M.D., 490 Post St., San Francisco, Calif.

Mr. John Hunton, Executive Secretary, California Medical Association, 450 Sutter St., San Francisco, Calif.

Colonel W. T. Harrison, Regional Medical Director, U. S. Public Health Service, Appraisers' Bldg., San Francisco, Calif.

William P. Shepard, M.D., Medical Director, Metropolitan Life Insurance Co., 600 Stockton St., San Francisco, Calif.

William Kiger, M.D., Southern California State Chairman, Procurement and Assignment Service, 1930 Wilshire Blvd., Los Angeles, Calif.

Doctor Harold A. Fletcher was elected as permanent chairman of the committee. Doctor B. O. Raultson was made chairman of the Southern California part of the committee in order that the work of the northern and southern parts of the State could be coördinated more efficiently without the necessity of frequent meetings of the committee as a whole. Meeings of the full committee were held on July 23, 1945, and on December 14, 1945, at the California Medical Association headquarters, 450 Sutter St., San Francisco.

The relocation of returning veteran doctors was one of the main problems with which the committee was faced. Of particular importance was the problem of placing returning veterans in desired residencies with hospitals, and listing other opportunities of refresher courses. It was the opinion of the committee that as the Procurement and Assignment Service had the authority to guide the relocation of physicians, this program should continue under the direction of Procurement and Assignment, and until February 12, 1946, this was left to the Procurement and Assignment Service. At that time Procurement and Assignment Service issued a directive discontinuing the policy of classification of doctors and now serves only as an agency to point out places needing new physicians.

Plans for coördinating and channeling requests for residencies and refresher courses were worked out, in order that returning veteran doctors could find opportunities with least delay. Doctors Raulston and Chandler acted as a subcommittee to coördinate the work of the medical schools and approved hospitals along these lines.

The question as to whether the present Medical Practice Act needed certain revisions to protect the people of California, as well as other states, under the present regulations for licensing physicians was discussed at length and the committee voted to request the Council of the California Medical Association to undertake a comprehensive study of this question.

The committee has made every endeavor to correlate and coördinate the work of the American Medical Association Committee of Postwar Service and other agencies working on these problems.

Respectfully submitted,
Harold A. Fletcher, *Chairman.*

ADOPTION LAWS

Executive Group

Philip K. Gilman, Chairman
George H. Kress
Donald G. Tollefson

To the President and the House of Delegates:

During the last year, at the request of the State Social Welfare Board of the California Department of Social Welfare, a special committee consisting of Philip K. Gilman, Donald G. Tollefson and George H. Kress was appointed to represent the California Medical Association in conferences made possible by a donation from one of the California Foundations, through which it was hoped to bring in a report to be submitted to the next California Legislature; with recommendations for changes in existing laws, through which the health and other welfare of foundling children would be better safeguarded.

Several meetings have been held in San Francisco and Los Angeles, a study director and clerical aids having been employed to proceed aggressively with the plans.

In due time reports insofar as the same relate to the responsibilities of physicians in the adoption of foundling and other children will be called to the attention of members of the California Medical Association. In the meantime this progress report is presented for the information of C.M.A. members.

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* Deceased.

Respectfully submitted,
George H. Kress, *Secretary.*

LOCAL COMMITTEE ON ARRANGEMENTS FOR THE CONVENTION OF THE AMERICAN MEDICAL ASSOCIATION

Executive Group
John W. Cline, Chairman

To the President and the House of Delegates:

The American Medical Association will meet in San Francisco, July 1-5, of this year. The short time between the meeting of the House of Delegates in December, and the meeting in San Francisco has greatly increased the burden of making arrangements for this meeting.

The responsibility for these arrangements is primarily that of the San Francisco County Medical Society. The officers and members of neighboring Societies have been extremely coöperative and have expressed a willingness to help in any way they can. Arrangements are progressing satisfactorily, and it is believed that the American Medical Association will have a satisfactory session in San Francisco.

Respectfully submitted,
John W. Cline, *Chairman.*

ADVISORY PLANNING COMMITTEE

Executive Group
John Hunton, Chairman
Howard Hassard
Rollen Waterson
Stanley Cochems
Ben Read
Frank H. Kihm

To the President and the House of Delegates:

The Advisory Planning Committee has held monthly meetings, in accordance with the instructions of the House of Delegates, and has reported to each meeting of the Council. Recommendations of the Committee have been shown in the Council minutes, which have been printed regularly in the OFFICIAL JOURNAL.

In addition, the Committee has studied matters referred to it by the Committee on Prepaid Medical Care and has reported to that committee, which in turn has reported to the Council and the House of Delegates.

Respectfully submitted,
John Hunton, *Chairman.*

COMMITTEE ON PREPAID MEDICAL AND HOSPITAL CARE

Executive Group
L. R. Chandler, Chairman
Harry E. Henderson
Sidney J. Shipman
Jay J. Crane
Samuel Ayres, Jr.
William G. Donald
Peter Blong
John E. Young
Wayne E. Pollock
A. E. Moore
A. M. Meads

To the President and the House of Delegates:

Your Committee on Prepaid Medical and Hospital Care has met regularly since the formation of the committee, has studied California Physicians' Service, medical care and hospital plans elsewhere in the United States, surveys of beneficiaries of various types of medical care plans in California, has met with representatives of private insurance companies, employer and labor groups, has kept in touch informally with the Council of the California Medical Association and will submit a detailed report and recommendations to the House of Delegates at its 1946 meeting.

Respectfully submitted,
L. R. Chandler, M.D., *Chairman.*

COMMITTEE ON PREPAID MEDICAL AND HOSPITAL CARE

Executive Group
L. R. Chandler, Chairman
Sidney J. Shipman
Wayne Pollock
A. E. Moore
A. M. Meads
Peter Blong
H. E. Henderson
Jay J. Crane
William G. Donald
J. E. Young
Samuel Ayres, Jr.

To the President and the House of Delegates:

This committee was appointed at the 1945 Annual Session of the C.M.A. to study California Physicians' Service and other prepaid medical and hospital care plans both voluntary and compulsory and instructed to make periodic reports to the Council of the C.M.A., and to make such recommendations concerning the subject of study as the committee may consider advisable to the House of Delegates of the C.M.A. at its next regular meeting. This committee has had numerous meetings beginning July 15, 1945. These meetings were attended regularly by all the members.

In considering the problem of prepaid medical and hospital care, the committee has studied various documents, survey reports and other written information, including the Foote, Cone and Belding, the Mannix and the Knight-Parker surveys. The committee spent considerable time studying and informing itself on the present policies, management and operation of California Physicians' Service. It had a study made of C.P.S. by the Advisory Planning Committee of the C.M.A. and spent a full day with this committee in discussing its findings and report.

It had access to the report of the study of C.P.S. made by the National Physicians' Committee for the Extension of Medical Service. Meetings were held with the Medical Director, the Executive Director and the former assistant director of C.P.S. for Southern California. At the committee's request a survey of opinion of members of employed groups receiving health service from (1) C.P.S., (2) commercial insurance companies, (3) by closed panel health service organizations, was made by Knight & Parker for the committee. Mr. W. Glenn Ebersole made an extended study and lengthy report on twenty-two prepaid medical care and hospital plans in other states and spent one day with the committee discussing these findings. Doctor Philip K. Gilman, President, made a personal survey of several health service programs in other states and reported thereon at length to the committee.

The committee met with representatives of seven private insurance companies for a lengthy discussion. A meeting was held with representatives of the three hospital service agencies now operating in the State of California. A meeting was held with representatives of industry in California including officials of the San Francisco Employers Council, the Los Angeles Chamber of Commerce, the Los Angeles Merchants and Manufacturers Association and the California State Chamber of Commerce. A full day was spent with Mr. Jay Ketchum, Executive Vice-President of Michigan Medical Service and President of Associated Medical Care Plans, Inc., the recently organized agency of the A.M.A.

During deliberations the committee considered the proposals contained in the American Plan, submitted by the Association of California Hospitals; the California Plan, submitted by a group of private insurance companies; and a plan submitted through the Advisory Planning Committee of the C.M.A. by Mr. Ralph Walker, Executive Director of Hospital Service of Southern California.

Invitations were issued and attempts were made to meet with representatives of the California State Federation of Labor, California State Council of the C.I.O.

and the Brotherhood of Railroad Trainmen. No acceptances to these invitations were secured.

On the basis of these interviews, studies and deliberations, the committee unanimously agrees on the following:

1. That the medical profession in California should endorse and actively support the voluntary system of prepaid medical care.

2. That the California Medical Association continue its active sponsorship of a voluntary prepaid medical and hospital care program permitting free choice of physician and hospital.

3. That the voluntary system of prepaid medical care should be as comprehensive as is practicable but should not be complete, should require the beneficiary to share in the financial cost thereof and should avoid unnecessary hazards to actuarial and financial soundness.

4. That the administrative and overhead costs of the operation of C.P.S. are high and out of proportion to those of other voluntary prepaid medical care plans.

5. That all employers be urged to share in the cost of voluntary prepaid medical care, which is a deductible operating expense.

6. That the establishment of voluntary prepaid medical care plans in various states and localities is a new development. All such efforts have made costly errors and mistakes and California is no exception. The American Medical Association, recognizing these facts, has established an advisory board to aid in the organization, improvement and coördination of such statewide plans.

In view of the above studies and opinions your committee makes the following recommendations to the House of Delegates of the C.M.A. with the full knowledge that members of the House are the main body of Administrative members of California Physicians' Service, in order to provide a more satisfactory and efficient voluntary prepaid medical program in California:

1. That the contract offered to the public by C.P.S. provide both a service type to beneficiaries in a low income group and an indemnity type to beneficiaries whose income is above an agreed income level.

2. That fees paid to physician members under the fee-for-service type of contract shall be the only fee received by the physician and the monthly dues be the only cost to the beneficiary member whose income is below an agreed level.

3. That the system of payments to physicians by C.P.S. be changed to a designation of dollars rather than unit value.

4. That physician members be entitled to arrange for an additional fee paid directly by the patient, in addition to the fee paid by C.P.S., for such beneficiary members whose income is above the agreed income level.

5. That the beneficiary member be free to choose any licensed physician and surgeon, which includes an osteopathic physician and surgeon, and that C.P.S. make payments to any physician chosen by a beneficiary, whether or not such physician is a physician member of C.P.S.

6. That all physicians receive the same fee according to the fee-for-service schedule.

7. That the Board of Directors of C.P.S. revise the fee schedule biennially, this revision to be made upon the recommendation of a committee appointed by the Council of the C.M.A., and that this schedule be maintained at a level as high as possible to insure the greatest coverage for the greatest number at the maximum practical fee to the physician.

8. That the upper income level for fee-for-service be established at $2,400 annual gross income for an individual without dependents and $3,000 annual gross income for an individual with dependents. It is recognized that this income level requires revision periodically.

9. That hospital service must be on a Statewide basis and synchronized with medical service provided by C.P.S. If the administration of C.P.S. and the hospital service agencies in California cannot agree within 90 days on a unified program that C.P.S. proceed to provide Statewide hospital care as well as medical care in its contract.

10. That a survey by outside competent experts be made to determine the soundness of actuarial experiences and financial, business and operating procedures of C.P.S., and that all expense in connection with management and overhead be reduced to an amount adequate for efficient business operation.

11. That the Board of Trustees of C.P.S. be enlarged to fifteen members, four of whom shall be experienced lay business executives. Each member of the board shall be paid an appropriate fee for each meeting attended.

12. That in the operations of C.P.S. each component unit be delegated the necessary authority to fulfill its particular function and be made responsible for the authority. Concretely, we recommend that the Board of Trustees be allowed to function as a business body without interference from outside individuals or agencies; that the management executives of C.P.S. be granted similar authority and not be interfered with by the Board of Trustees. If the trustees, managers or others prove themselves incapable of performing their obligations, they should be replaced.

13. That the positions and duties of the medical director and assistants be reviewed with the recommendation that they be employed by the Executive Director on a basis consistent only with adequate medical direction, and be responsible to him.

14. That the term "professional member" be changed to "physician member."

15. That the management of C.P.S. use all effective means of keeping physician members informed of the operating procedures and financial status of the organization.

16. That the California Medical Association and its individual members continue sponsorship of California Physicians' Service and the voluntary systems of prepaid medical care. Every possible aid shall be given to the successful operation of these plans and to active cooperation with the Council on Medical Service and Public Relations of the American Medical Association.

Félix Dujardin (1805-1860).—The work of one of his predecessors, O. F. Müller, led Félix Dujardin to a simpler division of microörganisms into bacteria, vibrii, and spirilla. For his criticisms of the work of another, C. G. Ehrenberg, he was much taken to task. However, he abided by his own observations only, and did not hesitate to point out when they departed from the precepts of Ehrenberg. When it was said that he had poor microscopes and an inadequate knowledge in their use, he convincingly disproved the charge by inventing an apparatus which doubled the strength of the microscope of that period.—Warner's *Calendar of Medical History.*

Theodor Schwann (1810-1882).—The cellular study of human tissues by Schwann was stimulated by a chance conversation with Schleiden, who had established the cellular nature of plants in 1831. Schwann's classic on the cell theory was published in 1839. He demonstrated the influence of organisms and lower fungi in producing putrefaction. The germ theory of Pasteur, and its application by Lister is traceable to his influence.—Warner's *Calendar of Medical History.*

ANNUAL COUNTY MEDICAL SOCIETY REPORTS

FIRST DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties.

Herbert A. Johnston, Anaheim, *Councilor.*

Imperial County Medical Society

The Imperial County Medical Society recently elected Dr. Charles Cutshaw of Brawley, President, and Dr. George Cole of Brawley, Secretary, for the ensuing year.

Due to the return of quite a few veterans we expect to have more complete and better attended meetings during the coming year.

MARIAN HUBBELL,
Secretary.

Orange County Medical Association

Many of our men are returning from service. This with a number of new men coming into the county is beginning to take some of the pressure off our men. The relocation of our service men is made difficult by a shortage of office space. In six months more this readjustment should be pretty well complete.

RUSSELL I. JOHNSON,
Secretary.

Riverside County Medical Association

The Riverside County Medical Association is proud to announce that 100 per cent of its members who have served in the armed forces are now released and have resumed their former positions.

The second Monday of each month at 8:00 P.M. the Association meets at the Riverside Community Hospital. A scientific program is presented and is followed by a business session.

The secretary of the Association publishes a monthly bulletin which is distributed the first week of each month.

W. K. TEMPLETON,
Secretary.

San Bernardino County Medical Society

The San Bernardino County Medical Society in the latter part of 1945 began to pick up in interest and attendance which has steadily increased until our meetings are now well attended. Our programs have been featured by talks and the showing of pictures of scenes in the various theaters of war, given by members returning from service in the armed forces, and interest has steadily grown.

Our meetings are held the first Tuesday of each month, October to June, both inclusive, and discontinued through the hot summer months.

Of the forty-five members who entered the armed forces, the following have been discharged and returned to private practice, either in San Bernardino County, or are pursuing further study and training before their return:

Kenneth H. Abbott, Russell E. Atkinson, M. G. Beaver, O. A. Bosshardt, Elmer O. Carlson, Wayne M. Caygill, James J. Cecil, Charles J. Clock, Wm. L. Cover, Francis L. Crowley, T. F. Ford, Harold G. Gentry, Arthur R. George, Joseph S. Hayhurst, Gordon Helstrom, Cecil W. Hoff, Eugene H. Hull, Leland C. Jacobson, Joseph Langer, N. B. Lawrence, Frank C. Melone, Ben D. A. Miano, H. Milford Nelson, James R. Savage, Philip M. Savage, Jr., Leonard M. Taylor, Marcus D. White, Delbert B. Williams, Robert N. Williams, Julius Zelman.

Postgraduate meetings have not been held during the past year, but we expect to again hold them in the coming year.

ARTHUR E. VARDEN,
Secretary.

San Diego County Medical Society

Cessation of much of the war production activities in San Diego County has brought little relief from the work being done by the Society members. Approximately half of those in military service have returned and are getting back into civilian harness. As elsewhere, the great problem has been to find office space for them. The situation is critical and the Society through the P. and A. Committee is doing its best to relocate these returning veterans. They are beginning to take over some of the load that those remaining behind have been carrying. We are looking ahead with some hope and apprehension to the question of offices for those still to come home.

During the past year we admitted 24 new members, about half of whom were veterans seeking new locations. A large list of applicants is still to be acted on, and the Society is considering the extension of its probationary period from six months to one year.

Hospitalization is still a matter of concern with a shortage existing as during the war period. This is especially acute in the case of those suffering from tuberculosis.

Under consideration is the matter of securing an executive secretary for the Society. Within 20 years we have grown from a small group of about one hundred to a large group of approximately four hundred. A full time man is needed for the job of secretary for the duties involved have expanded to such a degree that no man in active practice can carry on efficiently. The plan is still quite nebulous as yet and will receive our most careful consideration.

Regular monthly dinner meetings are now in full swing, but we are again faced with the problem of space to accommodate the greatly increased membership. The military group stationed here in Southern California has afforded us splendid programs for which we wish to thank our comrades in arms. (?)

The Emergency Medical Service under the O.C.D. has "folded up" but we are continuing on a peacetime disaster basis under the Red Cross. Thanks should be given publicly to Dr. Toomey who laid the foundation for our most efficient medical setup and carried on until he himself was called into service. As we look back over those hectic days, it seems astounding that such an organization was built up and maintained while he carried on, together with his committee, the private practice of medicine with the tremendous influx of war workers.

Thanks should also be given to the Procurement and Assignment Committee under the chairmanship of Dr. Simpson for its efficient work. No committee has ever functioned so satisfactorily and faithfully as that group did. As stated before, it is now functioning as a relocation committee for our returning members.

We are infusing younger blood into our official family, especially from those who were in military service. We feel that they are in a position to take up the burdens of the Society with new vigor and perhaps a newer viewpoint after being away from private practice. It is our hope that the next few years will see a great expansion in activities and influence of Society.

W. H. GEISTWEIT, JR.,
Secretary.

SECOND DISTRICT

Los Angeles County.

Jay J. Crane, Los Angeles, *Councilor.*

Los Angeles County Medical Association

The past year has been an exceedingly busy one for the Los Angeles County Medical Association, its various standing and special committees, its Board of Trustees, its Council and its officers, because of the many and varied problems that developed with the end of the war.

Many months before the war ended a special committee on post war planning, Dr. Donald Charnock, Chairman, after many meetings developed a comprehensive program to lend all possible aid and assistance to members when they returned to civilian practice from the various theaters of action.

Most difficult of solution was the providing of adequate office space. All practicing members of the Association were requested to aid in this endeavor—to offer part time office facilities or to give up part of their own space to medical veterans until these veterans could obtain offices of their own.

As early as 1944, the Board of Trustees recognized the need to provide financial aid to some of the returning members. A voluntary assessment was established resulting in a fund which is used to grant emergency loans, without interest, to those returning members who have need for immediate funds to reëstablish themselves.

With the rapid growth in membership there developed a situation beyond the capacity of a committee on admissions to manage. In answer to this an indoctrination program, affecting all applicants, was developed and is now in operation. Applicants must attend a series of six lectures, two of which are held each month. The subjects of these lectures are: "Medical Organization," "Medical Ethics," "Medical Education and Medical Economics," and "Medical Malpractice."

After the applicant has completed attendance at all six lectures he meets with members of the various committees conducting this indoctrination course and must pass an examination on the subjects discussed before his application is acted upon by the Council.

On January 31, 1946, the Association celebrated its seventy-fifth anniversary with a jubilee banquet at the Biltmore Hotel's Bowl, attended by 900 members and guests, with Doctor George H. Kress acting as master of ceremonies. For this occasion an anniversary issue of *The Bulletin* was prepared, presenting the history of medicine in Los Angeles County for the past seventy-five years, together with the histories of the various branches and sections, health departments and pioneer hospitals. This history will be reprinted in monograph form to be presented to new members of the Association so that they may have an understanding of the background of the organization to which they belong.

With its reminiscences and satisfaction over past accomplishments, the Association's Diamond Jubilee was a happy occasion indeed. Straight furrows cannot be plowed, however, by looking backward, although an occasional glance behind is necessary to proper orientation. Like a boy in last year's coat, the Los Angeles County Medical Association has outgrown its home. There was confident belief on October 25, 1934, when the present building was opened, that it would serve our needs indefinitely. Now, slightly more than eleven years later, with a rapidly growing membership which will probably exceed 4,000 by the end of the year, the available room is quite inadequate. Membership in 1934 totaled 2,143.

The auditorium, with a comfortable seating capacity of about 300, accommodates section meetings nicely, but important general meetings which attract a large attendance must be held elsewhere. This alone is not of too much importance, since meetings of that size are seldom held more often than once or twice a year. The large area of the county encourages attendance at branch programs and militates against the success of general meetings in the headquarters building. If this were not the case, a large auditorium would be an urgent necessity.

The library sorely needs additional space for book stacks, work rooms for librarians, and study rooms. Much material has not yet been catalogued and accessions are steadily increasing. With a third medical school for Los Angeles now assured, and with increasing demand for facilities for postgraduate study, our library should be made one of the finest of its kind. More assistant librarians are also needed if the demands of members for research service are to be properly served.

The Association's office staff is badly crowded. There is not sufficient space in the area allotted to offices for the necessary corps of stenographers, bookkeepers, clerks and *Bulletin* personnel. Consequently, some must work in whatever available nook they can find elsewhere in the building. The routine work involved in handling applications for membership, transfers, payment of dues and innumerable requests for information and assistance from members and from the general public has become very heavy. Notices of meetings must be mailed and insurance premiums cleared on the group health and accident program. *The Bulletin* must be addressed and mailed twice a month, a most inconvenient task with present space limitations. Members frequently request that reprints or other material be addressed with the Association's addressograph facilities. Other duties are numerous.

The room upstairs is no longer adequate for use as a restaurant. It is, moreover, in constant demand by sections and other groups. The Auditorium is in use almost every night, and consequently the smaller groups must assemble upstairs. When dinners are served, caterers are called in. With the dining room enlarged and additional space obtained for the smaller meetings, it should be possible to resume serving meals to members at noon.

To predict the needs of the Association beyond the next four or five years is impossible under present unsettled and changing conditions. There is a large and apparently growing wave of immigration to California and especially to Los Angeles County. Over 200 applications for membership are now pending. No one knows to what extent this will increase or how long it will last. If it goes on for more than one or two years without recession all present plans will be grossly inadequate. There has been a tendency to decentralization, and retail business has pushed westward along Wilshire Boulevard and other thoroughfares. If this is to continue, it might be wiser to acquire a building site farther west for future use. If, on the other hand, the imminent construction of high speed freeways from outlying parts of the county tends to fix the center of retail business at or near the present downtown district, our location is ideal where it is, even if the existing building is eventually replaced by one of several stories. Informed opinion seems to favor the latter possibility.

Guided by these considerations, the Board of Trustees, with the approval of the Council, has instructed architects to prepare drawings preliminary to obtaining bids for the construction of an addition to the present building. This will provide additional room for the library, for the secretary's office staff, for committee rooms, and will permit enlargement of the dining room. The cost of construction would be well within the Association's means and it seems to be the most economical way to meet the needs of the foreseeable future. An architect's sketch of the building as it would appear if enlarged according to plan will be found on page 174 of the 75th Anniversary Bulletin. There is, of course, no assurance that shortages of materials and labor may not delay construction indefinitely.

Long range plans for the future should consider fully the eventual needs of the geographic branches of the Association. The largest of them, repeating the history of the parent organization, will find as they approach a membership of four or five hundred, not many years hence, that a permanent home with auditorium, lounge, and a reasonably adequate branch library is not only desirable but almost necessary. Smaller groups can meet at any convenient cafe or hotel dining room but, as membership increases, temporary expedients become unsatisfactory. It is to be hoped that there will be the same careful conservation of funds in the future as in the past, and that the Association will at all times be in a position to assist its component units to obtain suitable facilities as each attains the requisite size. Likewise, each of the larger branches should conserve its own funds with this end in view.

Much credit for carrying on the innumerable tasks of the past year goes to members of the various committees who have rendered yeoman service in meeting many very difficult problems.

E. T. Remmen,
Secretary.

THIRD DISTRICT

Inyo-Mono Counties, Kern, San Luis Obispo, Santa Barbara and Ventura Counties.

Harry E. Henderson, Santa Barbara, *Councilor.*

Inyo-Mono County Medical Society

It has become our policy to welcome, as associate members, our dentist colleagues. Being geographically isolated from their own county societies, Inyo-Mono dentists attend and hold office in our Society.

The year 1945 has shown what united action by physicians of a Society can do in remedying problems facing us.

On July 1, 1944, we adopted as our official fee schedule for industrial accident work, the C.M.A. schedule compiled in 1942, and presented to insurance companies of this State on December 30, of that year.

Since that time all insurance companies doing business in this area have fallen into line and are paying our fees in full, with two exceptions. Several companies were very graceful in accepting our schedule, a few were less so, but have now accepted it; while the two exceptions have been very uncoöperative. They have finally been notified by all of us that we will no longer accept accident cases under their insurance policies. We are holding the patients' employers responsible for the cost of medical and surgical care. We believe that it will not now be long before those insurance companies will see the light and begin to coöperate.

L. S. Bambauer,
Secretary.

Kern County Medical Society

The Kern County Medical Society meets every third Tuesday, except June, July, and August at a dinner session at Stockdale County Club under the presidency of W. H. MacDonald.

Dr. Sophie L. Goldman was president and Dr. Juliet Thorner, secretary. Dr. Vincent Rounds invited very excellent speakers throughout the entire year. On February 26, 1945. Mr. Glen Ebersole addressed the group of two hundred lay members at a dinner meeting discussing California Physicians' Service and Blue Cross Hospitalization. He also discussed Governor Warren's Health Insurance Program. This was a very successful meeting and we received many fine comments about it. During the September meeting, the Society unanimously endorsed the forthcoming C.P.S.-Blue Cross enrollment campaign to be carried out on a community basis, Bakersfield and surrounding communities during the month of February, 1946.

The November meeting: Dr. William H. MacDonald was elected president, Dr. James Stanton, President-elect, Dr. Frederick Wynia, Secretary and Treasurer. Board of Directors are as follows: Drs. J. M. Nicholson, H. A. Rivin, Lucille B. May, C. I. Mead, L. C. McLain, J. Headen Inman, Keith S. McKee. Delegates: Drs. Sophie Loven Goldman, J. Headen Inman. Alternates: Drs. F. J. Gundry, William H. Moore.

On July 15, 1945, Dr. J. Headen Inman died. His loss is deeply felt by all as a member and a loyal supporter of organized medicine.

FREDERICK O. WYNIA,
Secretary.

San Luis Obispo County Medical Society

The San Luis Obispo County Medical Society, with a membership of twenty-nine members in 1945, held eleven meetings, most of which were given over to scientific programs.

The membership of twenty-nine included the following who were in the armed forces of the United States: Elmer Bingham, U. S. Navy; Newell Nay, U. S. Navy; Charles R. Kennedy, U. S. Army; Albert Shershow, U. S. Army, and F. F. O'Reilly, U. S. Army. Of these members Drs. Bingham, Nay and Shershow have been honorably discharged and have re-located outside this county. Dr. Kennedy has been honorably discharged and has returned to his former practice in Paso Robles; Dr. O'Reilly is still in the U. S. Army, according to latest reports; Dr. Edison A. French, who formerly practiced in this county, was also honorably discharged from the U. S. Navy, has resumed practice in San Luis Obispo, and has been elected to active membership in this Society.

There were only two practicing physicians in this county in 1945 who were eligible for and were not members of this Society. There were no deaths among the membership during 1945. The following physicians have located within this county during the latter part of 1945 but had not established residency long enough to be eligible for membership in 1945 but plan on applying in 1946: Dr. John Aldis, Dr. Paul Kotin, Dr. Helen Tepper, Dr. Laurence Gaebe, Dr. Elvin Wical and Dr. Barry Smith, all in San Luis Obispo; Dr. Herbert Swartout in Arroyo Grande; Dr. R. H. Bossert in Paso Robles; Dr. Richard Walters in Atascadero; and Dr. Jack Sleath in Nipomo.

During the past year the Society members have played an active part on the staffs of the San Luis Obispo County General Hospital in San Luis Obispo and the northern Branch in Atascadero.

Meetings are held the third Saturday evening of each month, except July, and are usually alternated between San Luis Obispo and some other city in the county. Visiting or new physicians in the county are most welcome and urged to attend.

G. DAVID KELKER,
Secretary.

Santa Barbara County Medical Society

The Santa Barbara County Medical Society has an active membership of 127, of whom 9 are still in the armed forces. Regular meetings are held on the second Monday of each month (except July and August), at 8:15 p.m., at the Bissell Auditorium of the Santa Barbara Cottage Hospital. It is the policy of the Society to have prominent members of the medical profession from outside of Santa Barbara present papers at each meeting.

The annual meeting was held January 8, 1945, at the University Club. Forty-five members and fourteen guests attended.

The program during 1945 was:

February: Mr. W. Glen Ebersole, special representative of the C.M.A., "Results of Survey by C.P.S. Showing Trend of People in Regard to Socialized Medicine."

March: Malcolm R. Hills, M.D., Professor of Colo-Proctology at the College of Medical Evangelists, "Rôle of Anal Glands in Pathogenesis of Ano-Rectal Disease."

April: Captain John F. Flynn, Jr., United States Public Health, "Recent Advance in Treatment and Control of Venereal Diseases."

May: Samuel Ayres, Jr., of Los Angeles, "Common Errors of Diagnosis in Skin Conditions."

June: Commander Leonard T. Furlow, M.C., U.S.N.R., "New Procedures and Methods Used in Neurological Surgery."

September: Devoted to Business.

October: Helen M. Johnston, M.D., Director, Rheumatic Fever Program, State Dept. of Public Health and Assistant Clinical Professor of Pediatrics, University of California Medical School, "Diagnosis and Management of Rheumatic Fever."

November: John M. Brown, M.D., Clinical Professor of Oto-laryngology at University of Southern California, "Sinusitis." Also: Howard P. House, M.D., Assistant Clinical Professor of Oto-laryngology at University of Southern California, "Deafness and It's Modern Treatment."

December: Film dealing with "Sterility, It's Causes, Correction and Treatment."

During the year our Society was saddened by the loss of four of our members who were actively in practice. These men were: Walter S. Franklin, M.D. and A. J. Holzman, M.D., both of Santa Barbara; E. P. Murdock, M.D., of Guadalupe and Edgar D. Smith, M.D., of Solvang.

The Santa Barbara County Medical Society ended the year with most of its military veterans back into practice. It is hoped the remaining few will soon be with us.

CHARLES A. PREUSS,
Secretary.

Ventura County Medical Society

The Ventura County Medical Society has a total membership of 53. Five of these are inactive because of military service. Fourteen members have returned from service during the past few months and are now in active practice.

Meetings are held on the second Tuesday of each month at the Ventura County Country Club at Saticoy. An excellent dinner precedes each meeting. Members rotate in serving as program chairmen. The scientific meetings have included interesting and instructive motion pictures as well as lectures by prominent outside men and members of the Society.

As elsewhere, there is a shortage of nurses and hospital beds, but the fine coöperation shown by the doctors and hospitals has minimized these problems.

Members of the Society are active in the American Tuberculosis Association, the American Society for the Control of Cancer as well as civic groups for the study and control of local problems.

G. H. ARNOLD,
Secretary.

FOURTH DISTRICT

Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare, and Tuolumne Counties.
Axcel E. Anderson, Fresno, *Councilor.*

Fresno County Medical Society

During the year 1945 the Fresno County Medical Society held nine regular meetings, July and August being observed as a vacation period.

The Society meets at the University-Sequoia Club, and our scientific programs usually consist of a talk by one of the staff members of the University of California, Stanford or University of Southern California Medical Schools.

One program each year is a joint meeting of doctors, dentists and lawyers. This program is arranged by one of the three organizations, alternating each year. This meeting is held during the month of May. The afternoon is spent playing golf, and a dinner meeting, with an outstanding speaker, is held in the evening. One program each year is also held in conjunction with the Woman's Auxiliary to aid in coördinating the work of the Auxiliary with that of the Medical Society.

During the last three months of the year many of our doctors who were in the service returned relieving some of the strain thrown on the older doctors of the community during the war years. Many of these returning physicians have had difficulty in obtaining offices, but this situation is gradually improving.

WM. L. ADAMS, JR.,
Secretary.

Kings County Medical Society

During the year 1945, members of the Kings County Medical Society managed to take care of medical demands, and held eight meetings. Seven out of the nine members in the Service are back in practice again.

WILLIAM F. CHAMLEE,
Secretary.

Merced-Mariposa County Medical Society

The activities of the Merced-Mariposa County Medical Society have been rather limited during the past year, since many of the members are still in the service. Business meetings were held, however, from time to time, and a good time of fellowship enjoyed by those who were able to attend.

With the return of most of our members from the service, we are anticipating a year of greater activity, fellowship and coöperation. Regular monthly meetings with programs, sponsoring prospective speakers are being planned for the coming year.

C. C. Fitz Gibbon,
Secretary.

San Joaquin County Medical Society

At the end of 1945, the total active membership of the San Joaquin County Medical Society stood at 110 members of whom 33 were still actively engaged in the military service. During the year the membership was saddened by the death of five highly respected members: Doctor Boyd Merril Krout, Doctor John D. Dameron, Doctor John M. Hench, Doctor John J. Tully, Doctor Hunter L. Gregory. Five new members were added, three by election and two by transfer.

Ten regular meetings and one special meeting were held during the year in the club rooms of the Medico-Dental Building, 242 N. Sutter Street.

The quality of the scientific meetings was maintained on a high level by the following colleagues:

Jan. 4—"Radiologic Diagnosis of Chest Conditions," Dr. Seymour Farber, University of California.

Feb. 5—"War Injuries of the Extremities," Major Brown, Hammond General Hospital.

March 3—"Surgical Experiences in the U. S. Army," Doctor W. Curphy, Stockton.

April 10—"Health and Morale of the German Prisoners of War," Major Lester Tretheway, Stockton Ordnance Depot.

May 5—"Medical Education and Practice of Medicine in Brazil," Dr. H. D. Chope, Stockton.

June—Report on the meeting of the House of Delegates of C.M.A., Doctor Frank Doughty, Tracy.

Sept. 6—"Some Medical Problems of the U. S. Navy," Lt. Comdr. D. F. Cashman, U.S.N.R., Navy Supply Annex, Stockton.

Oct. 4—"Surgical Problems in the Pacific," Dr. Emil Holman, Stanford University Medical School.

Nov. 2—"Acute Pleurisy as a Dehydrating Phenomenon in Diabetic Coma," Dr. Louis Armanino, Stockton.

"Some Pathological Chest Conditions," Dr. Chas. Webster, Stockton, California.

Dec. 9—"Surgical Infection in Reconstruction Surgery of War Wounds," Capt. R. Rhinelander, M.C., U.S.A.

"Some Aspects of Fracture Treatment," Major P. Burack, M.C., U.S.A.

The special meeting was held on February 21st to hear the radio address of Governor Earl Warren on his "Sickness Insurance" program and for a discussion of the activities of the C.M.A. by Mr. Glenn Ebersole, Special Representative of the California Medical Association.

During the year the Society was served by the following competent officers: President, Dr. Yale Brody; Vice-President, Doctor Dora Ames Lee; 2nd Vice-President, Doctor Hugh J. Bolinger; Secretary-Treasurer, Doctor George H. Rohrbacher.

H. D. Chope,
Secretary.

Stanislaus County Medical Society

The usual scientific and social meetings were held by the Stanislaus County Medical Society during 1945.

At the end of the year a number of our members returned from the armed service, resulting in greater attendance and enthusiasm at medical meetings.

R. R. Treadwell,
Secretary.

Tulare County Medical Society

Tulare County Medical Society has held regular monthly meetings throughout 1945. Dr. Charles Mathias as President and Dr. James C. Malcolm as Secretary have provided interesting and instructive scientific programs at each meeting. Dr. George C. Keiper has acted as Program Chairman throughout the year.

At the present writing many of those who have been in the armed forces are back in civilian practice. We wish to extend a hearty welcome to Drs. Powell, Brady, DeBusk, Zumwalt, Barber, Cronemiller, Cooley, MacKinnon, Blasdel and P. D. Miller, this being the list of those who have returned as far as it has been compiled.

Plans are being formulated for an active year of society meetings. It is hoped that we can join with Kings County in some of the more instructive programs. The regular meeting date at Tulare County Medical Society is the last Thursday of each month. Meetings are generally held at the Hotel Johnson, Visalia, California.

Irvin H. Betts,
Secretary.

FIFTH DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties.

R. Stanley Kneeshaw, San Jose, *Councilor.*

Monterey County Medical Society

Regular meetings of the Monterey County Medical Society were held the first Thursday of each month (excepting June, July, and August). The meetings were alternately held in Salinas and Monterey.

The roster of the Society now includes seventy-six members. Of this number ten still remain with the armed forces. The Society lost two of its members through death. These were Dr. G. H. Taubles of Carmel, California, and Dr. Walter L. Teaby of Monterey, California. Dr. William A. Carnazzo and Dr. Harry Powers were elected members of the Society, the latter through transfer from the Los Angeles Medical Society.

Guest speakers for the meetings included Dr. Stanley Kneeshaw, Mr. Glenn Ebersole, Mr. A. J. Davina, Dr. LeRoy Brooks, and Lieut. F. P. Shidler. Subjects presented and discussed were State Medicine, Health Legislation, E.M.I.C. program, C.P.S., Gastric Surgery, and Abdominal Injuries. For the April meeting the Society members were guests of the Fort Ord Hospital Staff. Several papers including case reports were presented. Subjects included Perforated Peptic Ulcer, Meningitis, Treatment of Pilonidal Cyst and War Psychoneuroses. Several of the meetings were featured by motion pictures.

S. A. Carnazzo,
Secretary.

San Benito County Medical Society

The San Benito County Medical Society has six members, all in active civilian practice. Two members transferred to other counties upon their return from military duties. No meetings were held during 1945.

John J. Haruff,
Secretary.

San Mateo County Medical Society

The following is a report of the San Mateo County Medical Society for 1945:

The present membership of the San Mateo County Medical Society consists of 100 active members; 6 associate members and 4 members still in the armed services. During the year 8 members were added to the Society. Twenty-seven of our members entered the military service. All except four of these have returned to their civilian practices.

All the members that were added during the year were declared essential by the local and state Procurement and Assignment Committees. Over 100 physicians have sought to enter practice in this county during the past year. These men were interviewed by a special representative committee of our Society, the purpose of which was to acquaint the applicants with the medical situation in this county. As a result of these interviews, about 60 per cent of the men failed to actually apply for membership.

The agreement by which the building belonging to San Mateo Community Hospital had been used as an Annex to Mills Hospital has recently been revoked. The building is to again revert to San Mateo County.

Paul Sweeney,
Secretary.

Santa Clara County Medical Society

The Santa Clara County Medical Society was gratified by the return to civilian practice of forty-four of its members from the armed forces late in the year of 1945. Many have commended the County Procurement and Assignment Committee for its work in advising and assisting the many physicians who have considered locating in Santa Clara County.

A formal announcement of the return to civilian practice was carried in various newspapers by the County Society, and every effort has been made for these doctors' original patients to return to them.

We have an active Visiting Nurse Association which includes the Metropolitan visiting nurse, the Red Cross nurse, and other visiting nurses who do hourly nursing rather than regular nursing, and this is under the supervision of the physician. This is paid partly by funds from the community funds, and partly by the individual patient.

The American Cancer Society now has an office and a secretary, and is coöperating very efficiently with the Tumor Clinic which has been functioning for four years. This office does most of the paper work, supplies transportation, checks the patients for reëxamination, and is also providing hospital beds for needy patients and beds for terminal care.

The County Tuberculosis Association has an X-ray Trailer service which has gone very extensively throughout our community, screening individuals free of charge. The small stereoscopic plates made are checked by doctors in our County Society who are qualified to read the plates, and any malnormalities are referred to the family physician. Further checks are then made, so we have a very active crusade against tuberculosis in this community.

We have found in our community considerable misunderstanding in regard to the Crippled Children's Act as set up by our State Legislature, and we are having explained in our County Society the facilities as covered by this act, and then endeavoring to use this clinic as a teaching clinic so that we can be informed of the newer methods in the care of crippled children.

We are actively engaged in the plans of the establishment of a Blood Bank using Red Cross facilities which can aid in our obtaining a Blood Bank of sufficient size for our community need.

A committee has been designated to explore the value of obtaining an Executive Secretary for the Society.

The returning servicemen are very definitely a benefit to our Society with their interest, knowledge, and coöperation in helping these above-mentioned activities become functioning projects.

FRED W. BORDEN,
Secretary.

Santa Cruz County Medical Society

Under the able leadership of President A. A. Cowden, the Society had a very successful year. With the easing of wartime limitations and restrictions it was possible to hold seven meetings. In February, Commander Merrill Mensor, U.S.N.R., addressed the members on the subject, "Medical Impressions in the South Pacific." At the February 27th meeting the subject of "Prepaid Health Insurance" was discussed. Councilor Kneeshaw and State Senator H. R. Judah were present and participated. In April, Doctor Francis Chamberlain presented a paper on "Modern Advances in the Treatment of Heart Diseases." At the May meeting, Doctor Ernest W. Page discussed "Management of Toxemias of Pregnancy." Doctor Henry Brainard was the speaker at the September meeting and the subject was "The Pneumonias." In October, Doctor Leon Goldman spoke on "Acute Cholecystitis and the Patient with Common Duct Disease." The December meeting was the annual business meeting at which time officers for 1946 were elected. We are happy to report that, at the close of 1945, all but two of our military members had returned and resumed private practice.

SAMUEL B. RANDALL,
Secretary.

SIXTH DISTRICT

San Francisco County.
John W. Cline, San Francisco, *Councilor.*

San Francisco County Medical Society

Last year was one of transition from wartime to peacetime economy for the San Francisco County Medical Society. In common with the rest of the nation, the occurrence of VE and VJ days found the Society prepared for coming events in several ways and unprepared in others.

Careful planning by preceding Boards of Directors proved of great value. The Special Service Fund, a fund accumulated by civilian doctors for the benefit of their colleagues in the military service had grown to decent proportions and was ready for use. In fact, it had already been used for the purpose for which it was conceived.

Contributions to the Fund were discontinued as of last year. During the life of the Fund, which was established in 1942, some $66,000 was contributed by 395 members of the San Francisco County Medical Society. Disbursements from the Fund amounted to more than $3,000, leaving a balance of some $63,000 available for further enterprises to benefit service doctors.

Among other efforts to help veterans was the formation of a Veterans' Committee. This committee supplemented the activities of the Special Service Fund Committee and consisted of a majority of veterans. It made every effort to secure office space, living accommodations, hospital facilities, and to solve other problems confronting doctors on their return to civilian life.

In January of 1945 the Board authorized the appointment of a lay executive secretary to take over many of the duties previously imposed upon the secretariat of the Society. This move became necessary with the increasing pressure of social, economic and political problems that were fast becoming sufficiently burdensome to require the attention of a non-medical person who could give special attention to these fields. The Society elected and appointed Mr. Frank J. Kihm on September 10, 1945.

In the political field, the Society supported its parent organization, the California Medical Association, in its stand in favor of reducing the cost of medical care to the individual by fostering prepaid medical care plans.

In the local field, the Society had representatives attending the meetings of the Health Committee of the Board of Supervisors. Developments of the municipal Health Service System were closely followed by representatives of the Society, resulting, on December 5, 1945, in a request for an increase of 15 per cent.

The Irwin Memorial Blood Bank continued to grow. In 1945 there were 1,500 donors more than in the preceding year. Bloods distributed were 1,300 higher in 1945 than in 1944.

A program of public relations was started which produced good results both in newspapers and broadcasting. Out of eight radio stations in San Francisco, five are coöperating with the Bank by giving announcements gratis.

Membership of the Society at the end of the year totalled 1,283. There 101 applications acted upon, of which 87 were accepted for membership in the Society and 14 were rejected.

ROBERTSON WARD,
Secretary.

SEVENTH DISTRICT

Alameda and Contra Costa Counties.
Lloyd E. Kindall, Oakland, *Councilor.*

Alameda County Medical Association

The past year has been one of tremendous activity on the part of the Alameda County Medical Association.

We have employed a full-time lay executive secretary, Mr. Rollen Waterson. A Bureau of Medical Economics has been established to handle our problems in credits and collections; to provide auditing, accounting and billing services; to provide an account-financing and postpayment service; and to exist as our published and advertised *guarantee* of medical care for all of the people of these communities, regardless of ability or inability to pay. We have begun the publication of what we believe is an excellent *Bulletin*, the last issue of which ran to 60 pages. We have reorganized the Association along more democratic lines, and streamlined our work with the establishment of branches in Oakland, Berkeley, Alameda and the South section of the county. Through these branches, our members in each community may handle local problems more effectively and expeditiously. We have a total of 46 committees in the Association and its branches, all of which will be active and working before the year is over.

The single accomplishment of which we are most proud is that of having no returning service members, to date, who have not been provided a place in which to practice. The dearth of office accommodations is as great in the Eastbay area as anywhere in the nation, but the sharing of space by many of our members and the work of a full-time real estate man, employed at the expense of the Postwar Benefit Fund, has solved the problem. Returning service members have been given cash loans, without interest, from the fund that was contributed by members who remained in civilian practice. Many other individual services were provided by our members and full-time lay staff for our physician-veterans—services that have taken our time and attention from some of our ambitious plans in other fields, but which we have considered to be of first importance.

Attendance at our meetings increases from month to month, with a record of 400 at our annual banquet in November.

The work of laying down a solid foundation for our projected program in public relations is nearly completed, and should be well under way before May 1st.

A group health and accident insurance program has been oversubscribed by our members and is now in force. Progress is observed in the solution of some of our medical protective problems. A close coöperation has been maintained with our neighboring Contra Costa County Medical Society. A method of handling complaints of patients against our members has been devised and placed in operation. Liaison with the dental and other health professions has been established. A survey of all health facilities of the county is to be undertaken in coöperation with the California Medical Association. Problems relating to the distribution of medical care have been carefully studied, particularly with reference to California Physicians' Service, the Permanente plan, and Blue Cross. Channels for the release and publication of medical news have been cleared, and the next few months will see the results of an improved press relations policy. Assistance and information has been given to other California medical societies that have contemplated the employment of full-time lay personnel. Our own office force now numbers twelve, with a monthly income, aside from dues, of more than $3,000.

These are but a few of our projects and plans. A complete report of our accomplishments under our new organization set-up will be published in *The Bulletin* in June, when the program will have been in operation for a full year.

It is our desire to so organize and conduct the work of the Alameda County Medical Association that it will become one of the county's strongest and most effective organizations within the year, and we believe that we will achieve that objective. Success has attended each of our many and carefully planned ventures during the first nine months of our new program, and we look forward eagerly to the final integration of our separate projects into what we believe will be a most effective professional and public relations program.

Dorothy Allen,
Secretary.

Contra Costa County Medical Society

A skeleton report of the activities of the Contra Costa County Medical Society for the year of 1945 should include the following:

Nine monthly meetings were held, which ended with the usual dinner party in December.

The membership at the time of this report totals 69. The following members have returned from the armed forces and have resumed civilian practice:

Crockett: Dr. E. C. Dietderich.
Martinez: Dr. Gaines L. Coates.
Pittsburg: Dr. Maxwell R. Bernstein.
Richmond: Dr. Henry H. Riklin.
Walnut Creek: Dr. Howard B. Flanders.
Antioch: Dr. Benjamin Woro.

Pittsburg has opened a well equipped and beautifully appointed fifty-bed hospital, and both Richmond and Concord have plans well under way for much larger and better appointed hospital units to replace the Richmond Community Hospital and the Concord Hospital respectively.

Contra Costa County is in the process of forming a closer and friendlier relationship with the Alameda County Medical Society in response to an invitation from the latter. Negotiations are under way which will permit the Contra Costa County group to participate in the functions of the Bureau of Medical Economics, as well as malpractice and health and accident insurance.

The population of the county is in a state of flux. There are definite indications of industrial expansion and an over-all increase in population and activity.

H. D. Neufeld,
Secretary.

EIGHTH DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Placer-Nevada-Sierra, Plumas, Sacramento, Shasta, Sutter, Tehama, Yolo and Yuba Counties.

Frank A. MacDonald, Sacramento, *Councilor.*

Butte-Glenn County Medical Society

The war is over and the members of the Butte-Glenn County Medical Society who served their country during the past four hectic years have all returned.

Four of the men from the Society served overseas in the Atlantic and Pacific areas. Commander John P. Fabian, Major Marvin Lee Chernow, Major Cyrennes, Leland Colm and Lt. Colonel Karl J. Chiapella. Of these four, only one was injured, Marvin Lee Chernow, and rather seriously at the time, but he made a successful comeback.

The remaining members of the Society kept the faith and to those in advancing years, the going was tough and strenuous. We held meetings in conjunction with the men who were stationed here in the Chico Air Service Command. The speakers were all capable men in their particular fields and the Association and contact were delightful.

All in all we can say with great pride that we did our part and did it well.

J. O. Chiapella,
Secretary.

Lassen-Plumas-Modoc County Medical Society

The Lassen-Plumas-Modoc County Medical Society meetings during the past year have consisted of short conferences between members and of telephone communications regarding the Medical Association.

Dr. Fred J. Davis, Jr., of Susanville continues as President.

J. W. Crever, Jr.,
Secretary.

Placer-Nevada-Sierra County Medical Society

Restrictions on gasoline and tires due to continued war conditions held our official meetings to three during the year.

1. The annual meeting of November 11, 1944, attended by eight members. At this meeting a resolution supporting the one passed by the directors of the San Francisco County Medical Society on October 3, 1944, was passed. This resolution opposed the action of the committee on Postwar Medical Service of the A.M.A. permitting temporary licensure without examination of physicians connected even remotely with the war effort to practice in California. Officers for the ensuing year were elected as follows: President, Dr. George A. Foster, Grass Valley; Vice-President, Dr. Paul D. Barnes, Loomis; Secretary-Treasurer, Dr. Vernon W. Padgett, Grass Valley. The last elected was to fill the office resigned by Dr. Robert A. Peers, Colfax, who has been the faithful and efficient Secretary-Treasurer of the Placer-Nevada-Sierra County Medical Society for the past 27 years.

2. Meeting January 4, 1945: Twelve members and guest, Dr. Ellis D. Sox, Chief, Division of Local Health Service, State Department of Public Health. At this meeting the proposed Budget and Recommendations of the Committee for the establishment of a Public Health Unit for Placer County were unanimously adopted and submitted to the Placer County Board of Supervisors.

3. Meeting February 17, 1945: This was a dinner meeting with twenty members present. Dr. Frank MacDonald, District Councilor from Sacramento and Lieut. Wm. Rector of DeWitt General Hospital. In addition there were twenty visitors. The guest speaker was Mr. Robert E. Burrill of the California Medical Association who talked on and answered questions from the floor pertaining to the Compulsory Health Insurance Bills before the State and National Legislatures. A resolution affirming and endorsing the Resolution adopted by the House of Delegates of the California Medical Association at special session held at Los Angeles January 4-6, 1945, was adopted unanimously.

4. In addition to the formal meetings held by the Society, our members were invited and a great number attended two professional meetings held at DeWitt General Hospital, Auburn. The first of these, March 27, 1945, pertained to insulin and electric shock in psychotic and manic-depressive patients, the guest speaker being Dr. Alexander Simon, Assistant Director of the Langley Porter Clinic of the University of California. The second was the two-day general medical meeting held at DeWitt General Hospital on the 14-15 of September, 1945, put on by members of the Hospital Staff and visitors from some of the leading teaching hospitals in the United States.

The membership of the Society is now 26 paying members. There are 11 members in the armed services whom we hope to have back by next year, and one life member, making a total of 38 members.

Vernon W. Padgett,
Secretary.

Sacramento Society for Medical Improvement

The Sacramento Society for Medical Improvement meets at 8:30 p.m. on the third Tuesday of each month in the auditorium of the Nurses' Home at Mercy Hospital, 40th and J Streets. No meetings are held during the vacation months of July and August. Programs are arranged by a committee, and the December meeting is devoted to Society business and the election of officers for the ensuing year. No bulletin is published by the Society, but the programs of the meetings are announced on printed notices which are sent to all local physicians and other interested physicians in nearby communities. Notices of the monthly meetings are also sent to physicians in military service at the adjacent army posts. The following speakers and programs were presented during the year:

January 16—Mr. F. J. O'Farrall, Chief, Division of Narcotic Enforcement, State of California: "Relationship of the Medical Profession to the Bureau of Narcotics."

February 20—Major D. J. Sullivan: "Psychosomatic Medicine."

March—Annual Banquet at home of Dr. J. B. Harris.

April 17—Dr. Lawrence Parsons, Reno, Nevada: "Relapsing Fever."

May 15—Mr. George Sim, Sacramento: "Estate Planning."

June 19—Lt. Comdr. R. C. Lofgren: "Penicillin in the Treatment of Syphilis and Skin Diseases."

September 18—Dr. H. Glenn Bell, University of California: "Treatment of Surgical Diseases of the Colon."

October 16—Dr. Gunther Nagel, Stanford University: "Transthoracic Approach to Carcinoma of Esophagus and Stomach."

November 20—Dr. Edwin B. Boldrey, University of California: "Neurological Aspects of Back Pain."

December 18—Annual Business Meeting.

The Society has a membership of 182. Drs. E. S. Babcock and D. L. McLean died during 1945. Dr. Lawrence Kolb is an honorary member.

Edmund E. Simpson,
Secretary.

Shasta-Trinity County Medical Society

The Shasta-Trinity County Medical Society has an active membership of eighteen. During the year of 1945 one member was transferred to another county. Four members have been released from the army service.

The Shasta-Trinity County Medical Society meets regularly on the second Monday of each month, except during the summer months of June, July and August. The Society has unanimously moved to adopt the proposed fee schedule of the California Medical Association for industrial accidents.

Julius M. Kehoe,
Secretary.

Tehama County Medical Society

The Tehama County Medical Society at its regular meeting the evening of December 6, 1945, elected the following officers for the year 1946: E. R. Wilson, M.D., President; F. L. Doane, M.D., Vice-President; R. G. Frey, M.D., Secretary and Treasurer. Doctor Donald Thompson was elected delegate and Doctor R. G. Frey, alternate. Doctor O. T. Wood has returned from service in the Navy in the South Pacific and resumed active practice. Doctor Roderick Thompson is still on duty with the Navy.

R. G. Frey,
Secretary.

Yolo County Medical Society

During the past calendar year the Yolo County Medical Society has continued to be very active. The problems associated with the terminal months of the war are familiar to all and need not be reiterated. We are extremely grateful that the war is over and that none of our physicians received any serious injury during their service. To date practically all of those who have served have been returned to us and are happily engaged in their practice. There are only two or three physicians who have not returned to Yolo County. The whereabouts of some of these are still not known to me. At the moment we are involved in a very acute nursing shortage which is hampering the practice of medicine very severely. It is our hope that the nurses who have been released will soon carry on in their previous capacities with the willingness that existed in that profession previously.

Emery Leivers,
Secretary.

Yuba-Sutter-Colusa Medical Society

Eight meetings of the Yuba-Sutter-Colusa Medical Society were held during the year. Two of these meetings were preceded by a dinner. At one of these, Dr. Evans and Dr. Richards of Stanford University gave interesting talks on "The Rh Factor and Penicillin Therapy." At the other Dr. Wayne of San Francisco gave many instructive facts on the subject of "Arthritis." One meeting was held at Camp Beale and proved to be unusually interesting. "Ligation of the Femoral Vein in the Treatment of Phlebothrombosis" and "Metacarpal Fractures" were discussed, and a skin clinic with presentation of cases was conducted.

During the year, Dr. Norman Culiner, Dr. William Vesquez and Dr. Ermorine Edwards were elected to membership. Dr. Desrosier, who had been in active practice in Colusa County, expired.

Dr. Neal Loomis, Lt. Commander in the Navy, and Dr. Leon Swift, Major in A.U.S., returned to civilian practice the latter part of the year.

The newly elected officers for 1946 were:

President, Dr. Leon Swift; Vice-President, Dr. Charles Keith; Secretary-Treasurer, Dr. Ermorine Edwards.

Ermorine Edwards,
Secretary.

NINTH DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties.

John W. Green, Vallejo, *Councilor.*

Humboldt County Medical Society

Under the able leadership of Dr. Nathan Wasserman the Humboldt County Medical Society had a very successful year in 1945.

The following-named members were released from the armed forces:

Dr. Joseph Brown, Dr. John Chain, Jr., Dr. Charles Falk, Jr., Dr. Max Goodman, Dr. O. R. Myers, Dr. Fred Olsen, Dr. Max Todd.

The Society was saddened by the loss of Dr. L. G. Kramar while serving in the United States Navy.

Dr. Marseille Spetz and Dr. Paul Roberts opened offices in Eureka; Dr. Carleton Schwartz in Fortuna; Dr. H. C. Portalupi in Arcata, and Dr. H. E. Wall in Crescent City.

A medical staff was formed at the General Hospital in Eureka.

A meeting was held with the insurance agents of the County for the clarification of the question of insurance work as related to the medical profession.

The employment of a full-time health officer for Humboldt County was passed by the voters of the County.

Wayne P. McKee,
Secretary.

Marin County Medical Society

The Marin County Medical Society carried the load very well all the year of 1945. The membership for the first half of the year was 34, since then nine members have returned to the county to resume practice. Five members are still in Federal Service, two members have transferred to other locations, two have gone to school to specialize, and one member has retired because of failing health. Three new members have been accepted by transfer from other counties. Including the doctors in the service we have now 54 members. Nine regular meetings were held in 1945, all were well attended and a good program was procured for each meeting. Good fellowship has always existed and is still present.

The doctors have all been overworked but little complaint has been made. With the return of the men from service all should be relieved somewhat. The nursing problem still remains bad as there seems to be no relief in sight. The two hospitals have done a good job in 1945, but they need more nurses to supply the nursing care for the beds they have. The obstetrical situation seems to be well in hand. Practically no cases are delivered at home, sometimes new mothers are forced to go home on the third or fifth day but no great difficulty has been encountered.

Carl W. Clark,
Secretary.

Siskiyou County Medical Society

The pressure on our civilian doctors was at its highest during the last war year, and consequently our Medical Society meetings were few and poorly attended. The highlight of the year, however, was a meeting at which Dr. S. J. Shipman spoke and laid the groundwork for a Tuberculosis Clinic in Siskiyou County.

Dr. H. L. Vidricksen has returned to his practice in Weed, after three years' service in the United States Navy.

It is certain that with other veterans returning to practice in this county and with the admittance of certain new members, we will have much more Society activity.

F. W. Martin,
Secretary.

Solano County Medical Society

A review of the activities of this Society for 1945 follows:

On January 9, 1945, the matter of a system of prepaid medical care was discussed and Dr. H. Randall Madeley, as Delegate to the C.M.A. meeting in Los Angeles, gave a comprehensive report.

The second meeting of the year was held on February 13, 1945, at which time the relationship between the Housing Authority and the California Physicians' Service was discussed and the new fee-for-service and tonsillectomy program outlined.

The March meeting was held March 13, 1945, and it was announced that there would be a physiotherapist on a part time basis at the Community Hospital. The Vallejo Merchants Association gave a report relative to shift of population in this area.

The April meeting consisted of a report on legislative activity. Correspondence was also taken up.

On May 8, 1945, Dr. Madeley reported on the California Physicians' Service election of State-wide officers. The Solano County Medical Society dues for 1946 was discussed.

November 11, 1945 the matter of Procurement and Assignment was discussed. The annual election of officers resulted in selection of Dr. John W. Green as President; Dr. C. C. Purviance, Vice-President; Dr. C. T. Alexander, Secretary-Treasurer. Delegate to C.M.A. House of Delegates, Dr. H. Randall Madeley and Dr. Felix Rossi, Fairfield. Alternates, Drs. Jones and Purviance.

The Annual Christmas Party was held December 17. It was well attended and a goodly number of the staff of the Naval Hospital were on hand to tell us some really sharp stories. The membership of the Society increased by four during the year. Dr. O. S. Nesting returned from the service, reëstablished his practice and the Medical Society was glad to welcome him back. The California Physicians' Service War Housing Plan closed as of January 1, 1946, in the Vallejo Housing Projects, which brings to a close another noble experiment born by the war.

C. T. Alexander,
Secretary.

Sonoma County Medical Society

The total membership of the Sonoma County Medical Society at present is 76, with 17 members still in military service. Three members were lost during the year—through the death of Dr. Henry S. Rogers and the transfer of two members to other Societies.

Ten meetings were held during the year. The April meeting was a joint meeting of the Society and the Ladies' Auxiliary. In July, the doctors and their wives were guests of Dr. and Mrs Carroll B. Andrews, of Sonoma. Following an afternoon of golf, dinner was served at the Palms, after which the guests visited the new Sonoma Valley Community Hospital, at Sonoma.

Raimond F. Clary,
Secretary.

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* Deceased.

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EDITOR . . . . . . GEORGE H. KRESS, M. D.

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

Committee on Publications

George W. Walker, Chairman	Fresno	1946
F. Burton Jones	Vallejo	1947
R. H. Sundberg	San Diego	1948
George H. Kress, Secretary-Editor	San Francisco	ex officio

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Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

C.M.A. ANNUAL SESSION—MAY 7-10, AT LOS ANGELES

An Interesting Four-Day Session Has Been Planned.—This year's annual session,—California Medical Association's 75th, counting from year of founding in 1856—will reflect somewhat the stress and strain under which military and civilian medical practice has been carried on during the last five years.

The change from the war period and two-day, streamlined meetings to former pre-war and four-day schedule has not been made without complications, since adequate hotel accommodations are still somewhat difficult to secure.

Since Hotel Del Monte at Monterey remains in possession of the Navy, the only other sufficiently large hotel is The Biltmore in Los Angeles; and even there, owing to standing and prior commitments with other organizations, only limited facilities are available. Because of the heavy existing demands for accommodations, hotels do not seek convention trade.

Therefore an organization as large as the California Medical Association, which needs rooms for meetings of 13 Scientific Sections and its House of Delegates, Council and Woman's Auxiliary is somewhat handicapped when it asks a large hotel to inconvenience its regular trade and guests.

This explanation is here given so that those who will attend the meetings, may understand the conditions which faced the Committee on Scientific Work when it was instructed to plan a four-day annual session.

* * *

Thirteen Scientific Sections Will Hold Meetings.—In spite of existing material and other drawbacks, the Section Officers and Central Committee have been able to formulate programs on scientific topics that are of pertinent and important interest. The current issue of CALIFORNIA AND WESTERN MEDICINE presents the preliminary drafts of the programs that have been arranged for the two general meetings and the numerous conferences of the 13 scientific sections.

The annual session will begin on Tuesday, May 7, the first general meeting being the sole activity on that morning. At that conference will be received the message of President Philip K. Gilman, reports by representatives of other official bodies, and addresses by guest speakers.

A second general meeting will be held on

Thursday afternoon, commencing with the Clinical-Pathological Conference, to be then followed with papers by guest speakers.

Section meetings start on Tuesday afternoon and will be carried on through Friday noon. On Friday afternoon the Section on Medicine will join with the California Heart Association in presentation of subjects of mutual interest.

Effort has been made to have several panel presentations to be given on different days. These panel discussions have special lure and will be well attended.

* * *

House of Delegates and C.P.S. Meetings.—The Council will hold daily meetings in one of the Conference Rooms, and in the Music Room, the House of Delegates will convene for its first meeting on Tuesday afternoon, May 8th, its second meeting to be called to order on Thursday afternoon.

The Administrative Members of California Physicians' Service will meet during a recess period of the House of Delegates on Tuesday afternoon or evening.

All members of the California Medical Association are privileged to attend meetings of the House of Delegates and Administrative Members, except when these bodies are in executive session.

The Woman's Auxiliary will also hold meetings on several days.

Study Groups in Pathology and Radiology will hold conferences, the first in laboratories of the University of Southern California, and the Radiology Group, in the auditorium of the California Hospital.

The Cancer Commission will present an informative program at a special dinner on Thursday evening.

Entertainment features have been practically limited to the Dinner to the President, Wednesday evening having been designated for this function, with its accessory entertainment and dancing features.

Such is the tentative program. Any changes in arrangements will appear in the Convention programs.

What has been stated above should be indication that C.M.A. members who register for the meetings of this year's annual session will have no reason to regret their decision to partake of the benefits that come from such attendance.

On other pages, in this issue, appear additional notices concerning hotels and like items.

It is to be hoped that all C.M.A. members who can arrange their work, will plan to attend this year's annual session. Time so given will be well spent.

PRE-CONVENTION BULLETIN—REPORTS ON LAST YEAR'S ACTIVITIES SHOULD BE SCANNED BY ALL MEMBERS

In hospital rooms and other places where groups of physicians have occasion to meet, it not infrequently happens that one member of those present will engage in sharp and critical comment concerning the deficiencies of organized medicine, as represented by national, state and county medical societies.

Too often, the member who makes his criticisms is a physician who has shown only a casual interest in his own personal responsibilities as a member of the county, state and national medical organizations that have actually been founded to protect his interests, and to promote the public health.

* * *

Why Reports of Officers and Component Societies Are Worthy of Notice.—It is conceded that perusal of the official transactions of duly elected officers of medical organizations may often not be interesting reading. It should be remembered, however, that the reports of officers and committees as so recorded, again and again, represent much time and generous effort and work by the busy physicians who have been elected to official positions in medical societies.

That is why the reports appearing in the current issue of the OFFICIAL JOURNAL, under the caption, "PRE-CONVENTION BULLETIN," should be read, or given at least a hasty scanning.

If, among such reports on policies instituted and activities carried on, there be items to which a physician reader would take exception, then that physician owes it to himself and his profession to communicate his opinions thereon to one or more of those fellow members of his own county unit who, as delegates, have been elected to represent him in the House of Delegates of the California Medical Association.

The House of Delegates is the supreme authority in the California Medical Association; and any member of that House is privileged at its first meeting to present any resolution or resolutions that he may deem of sufficient importance to be called to the attention of his fellow delegates. A topic so submitted then can be discussed before the proper Reference Committee, and again on the floor of the House, when report is made thereon.

* * *

Organized Medicine Is Expressive of a Democratic Organization.—Certainly, no more democratic procedure than that could be demanded. It permits every member of the California Medical Association to have opportunity to present his opinions.

Wherefore, again, it is hoped that the PRE-CONVENTION BULLETIN reports of general officers, councilors, standing and special committees, and of county society secretaries will be given at least a cursory inspection by every C.M.A. member who wishes to do his bit,—(in collective endeavor with his fellow physicians)—to advance the best interests of scientific medicine and the public health.

CALIFORNIA PHYSICIANS' SERVICE AND VETERANS' ADMINISTRATION CONTRACT

V.A.-C.P.S. Contract Is an Important Milestone in Solution of the Problem of Adequate Medical Care.—So important to the future of medical practice in California and perhaps to the Nation is the contract for medical care for veterans of all wars,—recently entered into by California Physicians' Service and Veterans' Administration,—that comment is again made thereon in this column.

Every veteran may be construed, in one sense, to represent the average family unit of four persons (himself and three immediate dependents or relatives). Hence, since California has more than one million veterans within its borders, the family unit of four would indicate that four million of California's citizens could come within the scope of medical influence and friendship, through the contractural set-up now operating through C.P.S., by arrangement with V. A.

* * *

Future Will Offer Even Greater Opportunities for Service.—And if, as has been predicted, California, within the next several years, may have as many as two million veterans resident within its borders, the figure of four million interested and kindly disposed citizens then could be increased to eight million citizens!

Consequently, if the physicians of California render adequate and satisfactory medical service to the thousands and thousands of veterans in our State, it follows that these veterans, their families and friends will become natural supporters of those legitimate medical practice objectives concerning which the medical profession may have gone on record.

The above thoughts are of a generalized nature, but even so, they call attention again to basic political and other values when one possesses the good will of the electorate of California. In the present instance, much good can accrue to the medical profession of our State if adequate service is given to veterans.

* * *

V.A.-C.P.S. Plan Is Being Put Into Operation.—On another page of this issue (page 269) is a photograph of the officials who were present when the C.P.S.-V.A. contract was signed. Its inspection is convincing evidence that the state medical societies of Michigan, California and other commonwealths, whose representatives have signed or will sign these V.A. contracts, are rendering the most powerful of all aids that have as yet been brought forward, to indicate to national and state legislatures, the press and the public-at-large that state medical society agencies that are sponsoring voluntary prepayment plans for medical care of citizens,—(in opposition to regimented and compulsory sickness insurance laws), —are the legitimate and best answers to the problem of securing adequate medical care for all citizens.

How Organized Medicine May Be Benefited.—Attention has been repeatedly called to the fact that while surveys throughout the Nation have always indicated kindly regard by patients to their individual physicians, there had arisen in recent years, a feeling of more or less antagonism against medical organizations. Of course, this unhappy situation was due in good part, to misleading propaganda by the proponents of compulsory sickness insurance laws. However, so well fastened has this erroneous concept been established in the public mind, that medical speakers find it persistently expressing itself in antagonistic manner during forum discussions and similar meetings.

Here now, at long last, in the V.A.-C.P.S. contractural arrangement, lay citizens will have first-hand opportunity to set themselves aright concerning the real nature of medical organizations.

Provided, of course, that every individual physician will give wholehearted coöperation in the attainment of adequate medical service for veterans.

For members of the medical profession to fail in this opportunity, would lay the foundation for governmental and political medicine, a something that must not come to pass. Nor will it come to pass; because this time, we have a plan in which all physicians can play a proper part, leaving to experience the correction of any inadequacies that may arise.

Think This Over

Arguments for a state-controlled medical system lose their force in the light of the following editorial from the Christian Science Monitor:

"President Truman's citation of draft rejections as a compelling reason for the introduction of compulsory sickness insurance in the United States loses its plausibility on comparison with draft rejections in Britain where this insurance prevails.

"In his message recommending government medical care insurance, the President said, 'The number of those rejected for military service was about 30 per cent of all those examined.'

"But in Great Britain, which has had compulsory sickness insurance since 1911, the draft rejections were far higher. How they ran is indicated in the published Annual Report of the British Army. Rejections for the ten years ending with 1936 are available in the Annual Report for that year.

"During all the ten years, 677,515 were served with notice papers and 400,775 were rejected, or 59 per cent.

"Even allowing generously for the effects of a lower standard of living, if Britain after 25 years of sickness insurance, had a rejection rate practically twice that of America, there seems to be little argument in the draft rejections for socialized medicine."

As a postscript to this editorial, we quote Dr. John Cline of the California Medical Association, who declares, "There is nothing that government can do for you in the field of health insurance which you cannot do for yourselves and do better at less cost. The fullest advantages of health insurance cannot be attained by just compelling people to pay into a fund."

The facts and the record in Great Britain need thinking over before we consider any type of socialized medicine.—Ontario *Report.*

EDITORIAL COMMENT†

AUTO-CARDIOTOXINS IN ACUTE RHEUMATIC FEVER

In 1934, Burky[1] of the Wilmer Institute of Ophthalmology, Johns Hopkins University, discovered a new immunological phenomenon of wide clinical implications. Previous investigators were almost unanimous in their conclusion that it is impossible to sensitize or immunize rabbits against lens proteins of the same animal species. Homologous lens substance is apparently fully non-antigenic for rabbits. Burky found, however, that homologous sensitization is readily effected by injecting lens substance either mixed with or simultaneously with staphylococcus filtrate. Under the influence of this toxin specific antilens precipitins were formed, often of sufficiently high titer to cause opacities and other degenerative changes in the rabbits' own crystalline lens. Burky believed such adjuvant effects offered a logical explanation for human cases of endophthalmitis phacoanaphylactica.

Numerous substances other than staphylococcus toxin have subsequently been found to exert a similar adjuvant action in nonantigens or on vaccines of low initial antigenicity. The possibility that such adjuvant action may form a logical explanation for degenerative lesions in tissues other than the crystalline lens has been recently re-investigated by Cavelti[2] of the Hooper Foundation, University of California. He found that extracts or emulsions of homologous renal tissues are not antigenic for rats or rabbits. A high degree of antigenicity is conferred on these nonantigens by mixing them with heat-killed hemolytic streptococci. Following injections of the resulting mixtures, relatively high titer antirenal precipitins are formed, whose *in vivo* effect is the production of glomerulonephritis by means of reaction with the immunized animals' own kidneys.

These findings are essentially confirmations and extensions of earlier investigations by Schwentker[3] and associates of the Baltimore City Health Department. The Baltimore investigators found that both staphylococcus toxin and streptococcus toxin were successful adjuvants for immunization of rabbits against homologous kidney substance. Clinically they demonstrated that autoantibodies against human kidney were found in the blood of the majority of patients with scarlet fever, and that high-titer antirenal autoantibodies were often associated with scarlatinal nephritis.

In his latest report Cavelti[4] found that nonantigenic emulsions of homologous heart muscle can be rendered antigenic for rabbits by combining them with heat-killed hemolytic streptococci. As a clinical application he found that the serums of patients with acute rheumatic fever often contain autoantibodies against the human heart. Control serums obtained from nonrheumatic patients or hospital personnel were invariably negative. Twenty (or 55 per cent) of the serums of the 36 patients with acute rheumatic fever thus far tested had titers of about 1:320 in terms of serum dilution by the colloidal particle technique.[5] Titers in the neighborhood of 1:40 were obtained in 7 cases and negative or doubtful reactions in 9 cases (25 per cent). Repeated titrations of the same patient suggested that cardiophilic autoantibodies are present in highest titer during the early and more acute states of rheumatic fever, but that they tend to disappear when the rheumatic process becomes negative. In the few cases in which strong serological reactions against human heart muscle persisted the prognosis was unfavorable. Detailed studies of the relationship between titer, symptomatology and prognosis are now in progress.

Cavelti found that autoantibodies against skeletal muscle and connective tissue also can be produced by immunizing rabbits with homologous tissue products plus hemolytic streptococci. Clinical applications of these two new autoantibodies, however, have not yet been reported. Therapeutic methods against autoantibodies are yet to be developed.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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Venereal Disease and Blindness

Syphilis and gonorrhea are among the major destroyers of sight, and these diseases are responsible for approximately 15 per cent of blindness in the United States, it is pointed out by National Society for the Prevention of Blindness in a recent statement urging widespread observance of National Social Hygiene Day. Of the 230,000 blind persons in the United States it is estimated that about 34,000 lost their sight as a result of these diseases.

The importance of this problem may be realized from the fact that about 60,000 babies are born with congenital syphilis every year. Most of them develop a serious eye condition at some time in early life, unless they receive adequate medical care. Prospective mothers who have syphilis can bear healthy children if prenatal antisyphilitic treatment is administered in time; and a careful examination including a blood test usually can determine the presence of syphilitic germs.

Apart from the tragedy that enters every home in which a person has lost his sight, the cost of syphilitic blindness to the victims and to the taxpayers amounts to many millions of dollars annually.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

Scientific and General

CALIFORNIA'S STATE MEDICAL SCHOOLS AND PUBLIC HEALTH PROBLEMS*

Hon. Earl Warren,
Governor of California
Sacramento

I AM happy to be here to take part in celebrating the start of a health center on the Los Angeles campus of the University of California. I regard this as an important milestone in the history of our State. It will affect the health and happiness of our people for generations to come. I know, too, how pleasing this occasion must be to the members of the medical profession of Los Angeles and Southern California and to the alumni of the University—without whose interest this great forward step could not have been achieved.

RESEARCH NEEDED TO CONSERVE, INSTEAD OF DESTROYING LIFE

We are living at a time when the countries of the world are vying with each other to see which can make the most frightful atomic bombs. One day we are told that a single bomb has been perfected with the destructive power of ten thousand one-ton "block busters"—and the next day that one has been built that might tear the world asunder. Scientists in many lands are engaged in a feverish race to control atomic energy to destroy life. Radar contact has been made with the moon. Jet and rocket planes have been built that travel faster than sound and reach higher and higher into the stratosphere. Research is being applied to developing poison gases and biologic weapons.

It is high time that we concentrated in scientific research on building life instead of on its destruction. It is high time that we get back to the fundamentals of life—the cornerstone of which is health. Who can doubt that many of the diseases which take more lives than war itself could have been brought under control if the money spent on destruction in recent years had been diverted to the cause of better health? What miracles might have been wrought if the scientific manpower mobilized for death had been used for saving lives!

The natural bent of the scientist is to work for the preservation of life, not for its destruction. We know that our own scientists, who gave so much to perfecting the atomic bomb, would gladly devote the remainder of their lives to the benefaction of mankind if the world would only let them. We who desire the betterment of humanity's lot must support every movement for using research to prevent and cure human ailments. We must look toward a free exchange of scientific knowledge instead of its hoarding. We must use it in the greatest of all wars, which is the war to make life increasingly useful and desirable in every part of the world.

CALIFORNIA'S NATURAL RESOURCES MAKE FOR INCREASED RESPONSIBILITIES

Certainly these should be our aims here in California, where we have the newest civilization in the world and the most hopeful outlook. Here we have progressed within the lifetime of some people from a raw frontier to a highly developed industry, agriculture, commerce and culture. Like myself, many people born in this county of Los Angeles have seen it grow from less than 100,000 people to 3,500,000 in a half century. We have also seen the State grow in population during that period from a million to 9,000,000. If we husband our resources and make the most of our opportunities, California in the next two or three decades will attract twice as many people as we have now. Our State is larger than many countries, richer than most, and more desirable to live in than any. Certainly we must do everything we can to make it a better State, no matter how rapidly it grows. We must not permit it to become the victim of neglected health, nor of disregard for any other fundamental.

Because we are blessed with the most favorable living conditions in the world, we sometimes coast along without making a forthright attack on the problems that accompany growth and industrialization. I am afraid we did coast too much in years past in the field of public health. For years, we tolerated a completely antiquated Department of Public Health that did not measure up to the needs of the people and the times. However, we remedied this particular situation by reorganizing the Department in 1943. We made a proper division of responsibility between the State Board of Health and the director of the department, and installed business methods and functional controls. We now propose to do as much in medical education and research.

MEDICINE HAS REMAINED TRUE TO THE PRINCIPLE OF FREE PLAY IN RESEARCH

In no field has the wisdom of giving free play to research been more clearly demonstrated than in medicine. The experiments of Lister gave effect to the work of Pasteur. Mankind has been spared untold suffering because of the discoveries of the Curies. In our own time, we have seen the development of the sulfa drugs. These great blessings and many others have been brought about by unremitting study and research on the part of self-sacrificing men and women whose insight was little short of divine.

UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL IN SAN FRANCISCO

Many people of our State do not know that we have had a medical center at the University of California since 1872, located in San Francisco. In its entire existence, less than $2,000,000 has been appropriated to it by the State for buildings and other facilities. In spite of this, outstanding professional schools have been developed there that have done a creditable, although by no means adequate job.

CALIFORNIA HAS FELT THE NEED FOR MORE MEDICAL SCHOOLS

Two-thirds of the doctors in our State have had to seek their training in other parts of the country. From our point of view, this is most unsound. The percentage should be at least reversed. We should train our own youth, and fix our own standards. Unless we do, we shall be dependent on others for our supply of professional men—which is a perilous position, particularly in times of stress.

I was astounded to learn a few months ago that no area in the United States comparable to Southern California has so few medical teaching and research facilities. There should be a great medical center here in Los Angeles for the purpose of educating our youth and it is the plain duty of our State to provide it. Its research facilities should be available to the 4,000 doctors of Los Angeles and the thousands elsewhere in Southern California. They should be able to find inspiration and obtain assistance there.

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* Address given at the dinner, jointly sponsored by the Los Angeles County Medical Association and the Alumni Association of the University of California at Los Angeles, Hotel Biltmore, Los Angeles, March 21, 1946.

The information I obtained from our survey of medical teaching facilities in Southern California was confirmed by members of your Association, who had long been hopeful that the situation would be corrected. It was verified by Dr. Clarence Dykstra, who outlined his ambitions for the University. It was corroborated by officers of your Alumni Association and by Phil Davis, the Westwood member of the State Assembly. I was convinced that the condition not only should be remedied, but that this must be done at once—while we had the means to do so. I am indebted to Dr. Elmer Belt and the other members of your Association who urged this action upon me, because this made it possible for all of us to work together to accomplish the result we are celebrating here tonight.

PRESENT APPROPRIATION OF SEVEN MILLION DOLLARS IS FOR FOUNDATION OF A STATE MEDICAL SCHOOL ON THE LOS ANGELES CAMPUS

We now have securely in the State treasury $7,000,000, appropriated for this health center on the Los Angeles campus of the University. I believe that when I signed this bill two weeks ago, we laid the foundation for one of the great medical centers of the world. There is every reason to believe that it will be one of the greatest. The need is certainly present. The will to develop it certainly exists in the groups represented here tonight and among the people of this community. With the foundation thus laid, no power on earth can prevent it from being what you would have it be. I am happy that as Governor of this State, I could be a participant in the establishment of such a medical center in the city of my birth. I shall watch it grow through the years with keen anticipation and genuine pleasure. (Ed. Note. See p. 262.)

APPROPRIATION OF FOUR MILLION DOLLARS, PLUS ADDITIONAL FUNDS WILL PROMOTE GREATER DEVELOPMENT IN UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL AT SAN FRANCISCO

I am also very happy that I was able to further the completion of the medical center on the San Francisco campus by proposing and approving a $4,000,000 appropriation to complete the facilities of that institution. This and the other appropriations made since 1872 aggregate approximately the amount that is being made available for the health center in Los Angeles.

CALIFORNIA MUST BE IN THE VAN, NOT ONLY IN CURATIVE, BUT IN PREVENTIVE MEDICINE

With these two great institutions, we shall be able to keep abreast of the medical educational needs of this fastest-growing State of the Union—and we must do so. I want to see California become the foremost State not only in the study of medicine and the cure of disease, but also in the prevention of disease. To this end, we are bending every effort to coördinate our State Department of Public Health, our Department of Mental Hygiene, and the medical departments of the University.

RECENT PROGRESS AND CHANGES IN CALIFORNIA DEPARTMENTS OF PUBLIC HEALTH AND INSTITUTIONS

During the past three years, we have had a very comprehensive program of public health activities and with some very gratifying results. Not only have we reorganized our Department of Public Health, we have thoroughly revamped and modernized our old Department of Institutions. This latter is now in name and in fact the Department of Mental Hygiene. I am determined that in the operation of our mental hospitals, we will take California completely out of the "asylum age" and establish our State firmly in the "hospital age."

CALIFORNIA DEPARTMENT OF MENTAL HYGIENE SUBSTITUTES AN "HOSPITAL AGE" FOR FORMER "ASYLUM AGE"

In the last analysis, it will be cheaper even financially to do this, to say nothing of the human values involved. I am determined that we shall place the emphasis as much as possible on the prevention of mental disorders rather than on mere custodial care. We have made some progress—not enough to be satisfactory, but certainly enough to be stimulating. We have stripped the Department of Mental Hygiene of every extraneous function. Now it is devoting itself exclusively to the prevention and care of mental disease.

We have made the necessary appropriations for enlarging and improving these hospitals so that they will take care of our needs up to 1950. We are establishing a separate institution for epileptics, to end the medieval practice of confining them with mental patients. The overcrowding in present institutions to the extent of 6,000 men, women and children is to be relieved, not only through building new hospitals but also by making temporary use of two military hospitals, which have been declared surplus property by the Federal Government.

"MENTAL CLINICS," BOTH INSTITUTIONAL AND MOBILE ARE BEING PLANNED

We are establishing a new mental clinic here in Los Angeles comparable to the Langley Porter Clinic at San Francisco, and I want to see that clinic made a part of your health center.

I also advocated clinics at San Diego, Fresno and Sacramento, and that from all these we should have mobile units which could go into the most remote districts of our State. In this way we could help people in the first stages of mental illness, who, without attention, might develop into cases requiring hospitalization.

I am certain that it will be only a matter of a very short time before we are able to accomplish this, but the Legislature suggested that we delay establishing these additional clinics until we have a back-log of experience at Langley Porter and here. For this reason, I am intensely interested in the success of the San Francisco and Los Angeles clinics. What is done in the future throughout the State will depend largely upon what they do.

I am convinced that with an adequate system of clinics, we shall make it unnecessary for many people to enter a State hospital. More patients can be released from the hospitals than at present, and many who are released will never have to return.

LAWS ON COMMITMENT FOR MENTALLY ILL CITIZENS

Our laws for the commitment of mentally ill persons should be redrafted to wipe out the last vestige of connection with the criminal process. Until comparatively recent years, mental cases were handled in exactly the same way as criminal cases. There are still counties in the State which have no place other than their jails for housing mentally ill persons awaiting commitment. Within my own experience, I have seen mentally ill persons confined behind the bars of county jails after being brought in by a patrol wagon. This is truly a relic of the Dark Ages.

NEW CALIFORNIA INSTITUTIONS FOR SPASTIC CHILDREN

There is one group of unfortunate people who have never received the attention that should be shown them by their State. These are the victims of cerebral palsy. These people can and should be helped. We have recently laid the foundation to do so, and are establishing two Institutions for spastic children—one in the north and one in the southern part of the State. I hope this very important work and the institutions in which it will be done will be closely affiliated with the health centers of the University.

SURVEY ON HOSPITAL NEEDS OF CALIFORNIA ALREADY UNDER WAY

I want to see provision made for more hospitals in our State. Preservation of the public health requires that additional facilities be provided at the earliest possible time. If an epidemic such as the influenza of the last war should descend upon us, the hospital shortage would be disastrous. The need is particularly great in the rural areas of the State. We have finally succeeded in obtaining legislation creating an advisory council which will assist the Department of Public Health in surveying the hospital needs of California. We hope by this act and as a result of this survey to put our State in position to participate promptly in any Federal program for extending hospital facilities. We want to lend every encouragement to establishing private hospitals and medical centers.

CALIFORNIA NEEDS A SCHOOL FOR TROPICAL DISEASES OF THE PACIFIC AREA

I want to see a school for tropical diseases established in our University. As far as I have been able to ascertain, there is no institution in the country specializing in the tropical diseases of the Pacific. The germs have been brought to our country from the combat areas. A vast expansion of commerce and travel within the Pacific basin is inevitable. It therefore becomes imperative that we devote attention to the prevention and control of diseases peculiar to that area.

ADDITIONAL STATE SUBSIDY FOR CALIFORNIA SANATORIA WILL ENHANCE THEIR CAPACITY FOR SERVICE

I want to see a great improvement and further expansion of the tuberculosis hospitals in California. We improved our program for dealing with tuberculosis a year ago, by increasing the State subsidy to counties having facilities for the care of tuberculosis patients. I hope and believe that through this and other means, the standards of these hospitals will be constantly raised until they reach the limits of scientific knowledge and administrative efficiency.

FORWARD-LOOKING PROGRAM CONCERNING VENEREAL DISEASES

I want to see more venereal disease clinics established—clinics equipped with the most modern treatment methods and putting into effect a forward-looking program for the suppression of these diseases.

GOOD HEALTH IS THE CORNER STONE OF HAPPINESS

There is nothing more challenging than the opportunity to improve the public health in our State. Nothing is more fascinating than the problems involved in trying to do so. No service can bring more lasting benefits. The truest satisfactions in life are those growing out of the effort to advance the welfare not only of the people of our own generation but of those who will follow us. We can derive such satisfaction from our efforts to improve the public health—because good health is the corner stone of happiness.

HIGHEST PROFESSIONAL STANDARDS AND RELATIONSHIPS SHOULD BE MAINTAINED

Our goal is many-sided. It includes the prevention of disease so far as that can be accomplished. It includes treatment and cure, and bringing the health services to the people in all walks of life. If we can do these things and maintain the highest professional standards and relationships, then we shall indeed have measured up to our responsibility in this field. We shall have served both our own generation and the future generations for whom we are building this great health center.

WORK TO BE DONE MUST BE APPROACHED IN A SPIRIT OF COÖPERATION

Our job is never-ending. But if we approach it in a spirit of coöperation, without pride of authorship or opinion—with only the public welfare in mind—we can help to make strong and secure the foundation for happiness in every California home.

CONTRIBUTIONS OF MEDICAL PROFESSION TO AMERICAN AND ALLIED VICTORY

The medical profession made a great contribution to American and Allied victory. Thousands of our doctors put on the uniform of the armed services, and the story of their work at their battle stations is known to all of us. Those who could not go to war worked tirelessly to minister to our people here at home. Our gratitude is due to our physicians and surgeons, our dentists and scientists wherever they carried on. The service they have rendered to our people, and will render in the future, entitles them to the best training, the most comprehensive research, and every assistance that can be brought to them by the State.

STATE UNIVERSITY MEDICAL SCHOOLS WILL PROMOTE ATTAINMENT OF PUBLIC HEALTH OBJECTIVES

It is in this spirit that we celebrate the establishment of a great health center on the Los Angeles campus of the University of California. May it always be second to none!

Executive Offices, The Capitol.

THE RELATIONSHIP BETWEEN ANXIETY NEUROSIS AND DUODENAL ULCER WITH SPECIAL REFERENCE TO THE X-RAY FINDINGS AND TREATMENT*

LT. COMDR. THOMAS J. COX (MC), U.S.N.R.
AND
COMDR. BRUNO O. JUNNILA (MC), U.S.N.
San Leandro, California

THE psychogenic factor in the etiology of duodenal ulcer and the psycho-somatic nature of this disease have been stressed for a number of years by psychiatrists. These factors, however, are not fully appreciated or thoroughly understood by many physicians, nor is their importance sufficiently stressed in most present day text books of medicine.

The United States Naval Hospital at San Leandro, Alameda County, California, where this study was carried on, was commissioned on August 15, 1944, for the purpose of studying and treating the psychoneurotic patient who had been exposed to overseas duty.

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* This article has been released for publication by the Division of Publications of the Bureau of Medicine and Surgery of the U. S. Navy. The opinions and views set forth in this article are those of the writers and are not to be considered as reflecting the policies of the Navy Department, or the military service at large.

A large percentage of these men had been in actual combat. Approximately 70 per cent of the patients in the hospital entered with a "Fatigue Combat," "Fatigue, Operational," or "Anxiety Neurosis" diagnosis and about 30 per cent of the patients entered with medical or surgical diagnoses. All of these men had been overseas during the war and subjected to unusual physical and emotional strains for a period of about 6 months to 3 years (averaging about 18 months). No patients other than this group or our own staff members were admitted to the hospital.

Because of the nature of this hospital, an unusual opportunity afforded itself to observe the relationship of anxiety neurosis to duodenal ulcer as an etiological factor. The recognition of this factor lead to some modifications of the method of treatment. The relief of psychological stresses and strains which had been precipitating causes in the onset of the acute duodenal ulcer and also affect its healing was emphasized. An excellent opportunity has been had to study the x-ray changes which take place at various stages of ulcer development and healing.

The series of patients studied in this report numbered 161 (from August, 1944, to September, 1945), of which 83 were admitted with the diagnosis of duodenal ulcer and 78 with a neuropsychiatric diagnosis. The latter group also were found to have definite duodenal ulceration when studied at this hospital. All above patients had definite x-ray confirmation of duodenal ulcer and in most cases were followed with from 1-5 follow-up gastro-intestinal x-ray examinations during the course of treatment.

The age of these patients varied from 19 years to 42 years. However, the majority, over two-thirds, fell into the 19-30 years bracket.

HISTORY

The history of onset of ulcer symptoms in these two groups of patients did not differ to any appreciable extent. The onset of the classical ulcer symptoms of epigastric distress partially relieved by soft foods, soda or aluminum hydroxide and usually accompanied by nausea and occasional vomiting was preceeded in all cases by symptoms of anxiety, for a period of several weeks or months. The difference was merely in the degree and variety of the anxiety symptoms which were presented by the patient.

Those patients whose psycho-somatic complaints were chiefly confined to the epigastrium were usually given a gastro-intestinal investigation at an advanced base hospital. If no definite ulcer crater was visible at that time, a neuropsychiatric diagnosis was established. If positive evidence of ulcer was revealed by x-ray, then the patient fell into our "Duodenal Ulcer" group on entry here.

On the other hand, patients who developed varied psycho-somatic complaints and perhaps a more acute anxiety state with headaches, startle reaction, insomnia, violent dreams, and also had epigastric symptoms, were usually not given a thorough gastro-intestinal investigation. This was especially true if the gastro-intestinal complaints were not typical of ulcer, and these were classified with a straight neuropsychiatric diagnosis before being transferred to the United States.

This is not intended as a criticism of diagnosis at advanced base hospitals. Under the stress and rush of handling large groups of patients in combat areas, we realize (since one of us was stationed at an advanced base hospital for about 8 months), that there is not sufficient

TABLE 1.—*Anxiety Neurosis—Duodenal Ulcer Syndrome*

A Schematic Correlation of Clinical and X-ray Findings at Various Stages in the Progress of the Disease Under Treatment

Clinical Stage and Pathogenesis	Anxiety Symptoms and Signs	Epigastric Symptoms and Signs	Important GROSS Fluoroscopic Findings	Important Radiographic Findings
Acute 1. (Early Erosion) Onset to 4 weeks	Marked	Marked	Pylorospasm 2+ to 4+ Bulb Hypermotility 4+	1. Spastic Constriction 2. Niche rarely demonstrable
Early Subacute 2. (Beginning induration) 4-8 weeks from onset	Marked	Less Marked	Pylorospasm 1+ Bulb Hypermotility 2+	1. Spastic indentation 2. Sharp niche 3. Limited induration
Subacute 3. (Induration at Peak) 8-12 weeks from onset.	Diminished but present	Diminished but present intermittently	Bulb Hypermotility 1+	1. Heavy induration 2. Smooth niche 3. Limited spastic deformity
Late Subacute 4. (Induration Subsiding) 12-16 weeks from onset	Diminished but usually still present	Usually absent	Negative	1. Residual wavy induration 2. Shallow niche
Healed 5. Patient clinically and radiographically cured	Absent	Absent	Negative	1. Minimal induration occasionally

Note.—Time estimates in this clinical syndrome (left column) are naturally variable depending on the type of therapy and depth of anxiety state in the patient. Above are averages for our group. Without proper therapy the ulcer conceivably might become chronic after 3 or 4 months. This did not occur in any of our patients.

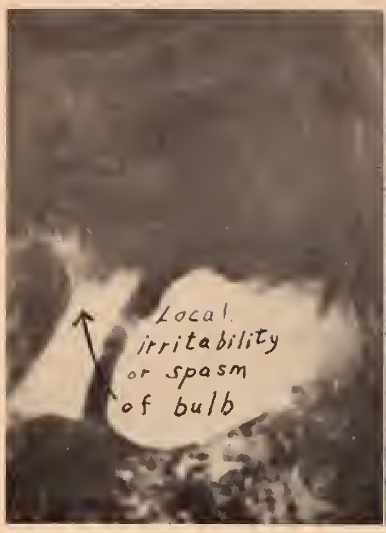
Local irritability or spasm of bulb

Fig. 1.—The spastic constriction of the entire lumen is characteristic of the acute stage.

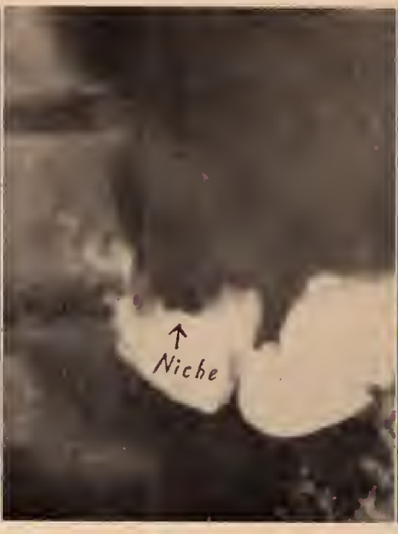

Fig. 2.—Characteristic findings in early subacute stage. The niche is pointed; the induration cup-shaped. The spastic deformity is confined to the ulcer area.

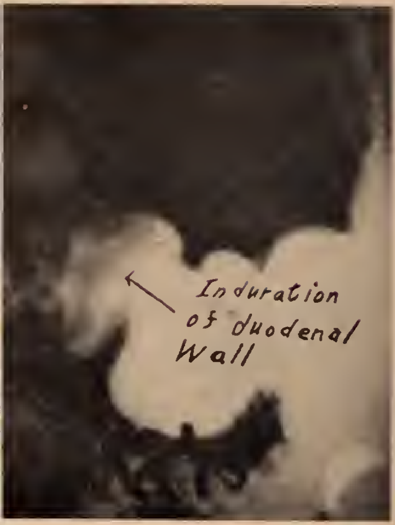
Induration of duodenal Wall

Fig. 3.—Characteristic picture of late subacute stage.

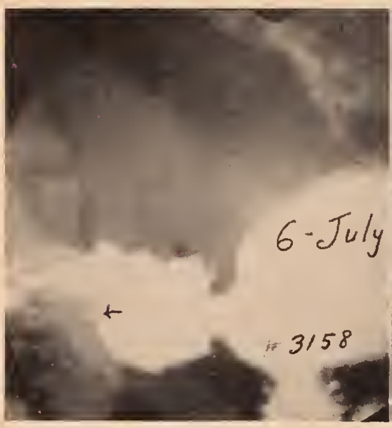

Fig. 1.—Early Subacute Stage. Small pointed niche (arrow). Some spastic indentation of the wall at ulcer site.

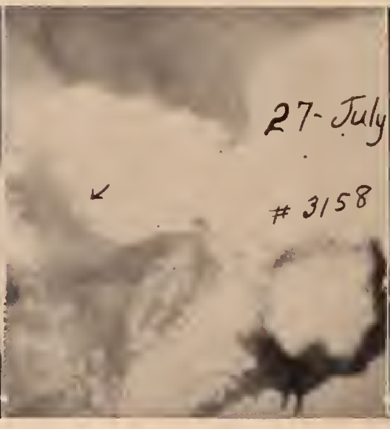
27-July
# 3158

Fig. 2.—Subacute Stage. Shows depression with some surrounding induration at the site of niche.

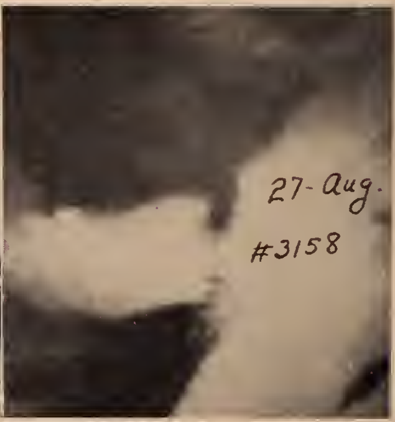

Fig. 3.—Healed.

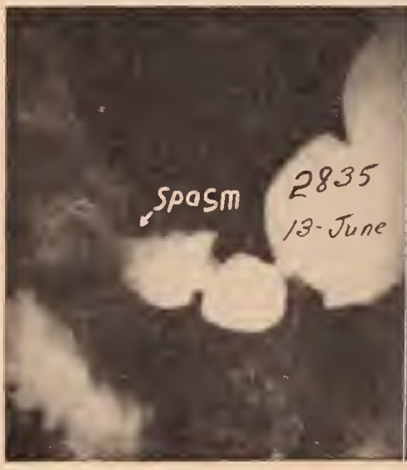
Spasm
2835
13-June

Fig. 1.—Acute Stage. Only the spastic constriction is seen.

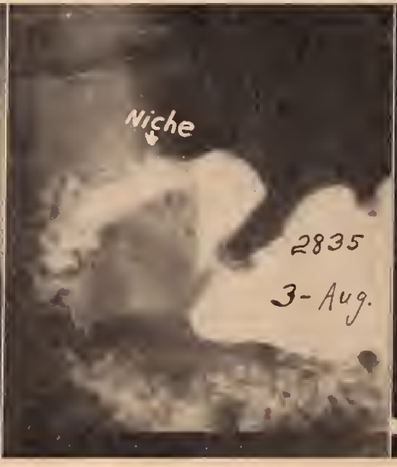
Niche
2835
3-Aug.

Fig. 2.—Subacute Stage. Niche now visible. Spastic deformity more limited.

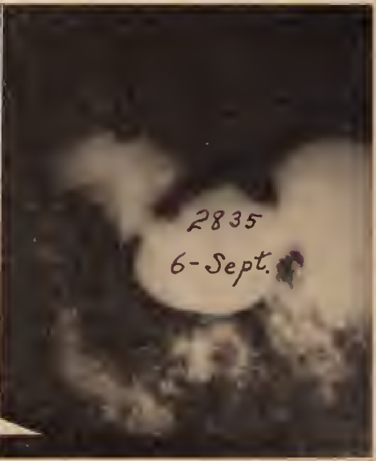

Fig. 3.—Healed.

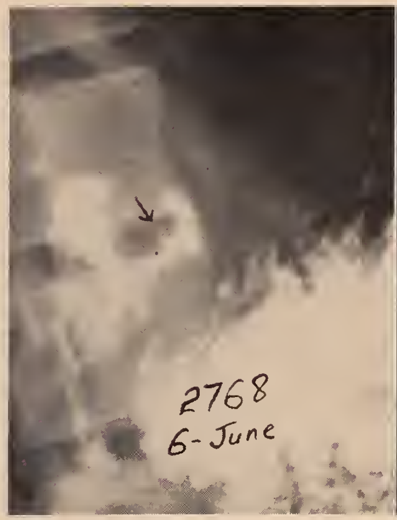

Fig. 1.—Early Subacute State. Niche, induration and spastic deformity visible.

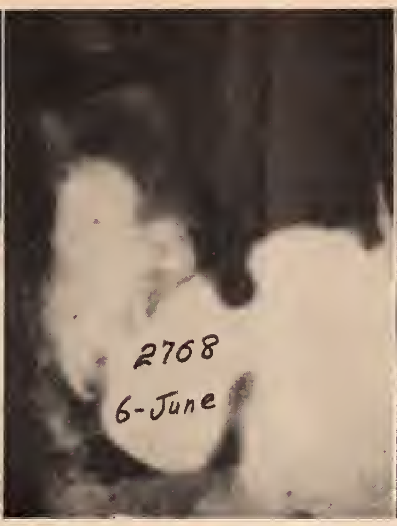

Fig. 2.—Early Subacute Stage. Spastic indentation and induration visible.

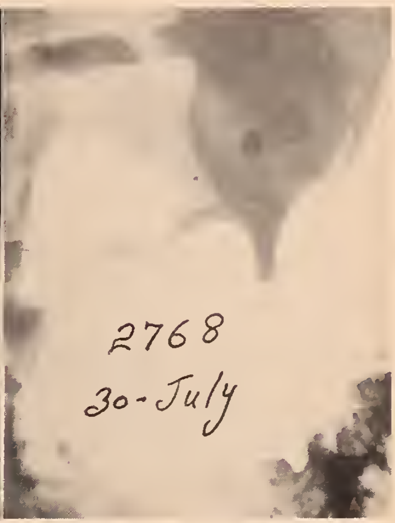

Fig. 3.—Healed. Minimal induration (dark area) visible at center of bulb.

time to make complete studies and only rough classifications of patients as to diagnosis can be accomplished. Whereas in this hospital, treating the patients, with rehabilitation to civil life, as the aim, we had ample time to study the patients and their previous histories.

The acute anxiety symptoms were apparently precipitated by three chief causes: (1) actual combat conditions, (2) worries about family affairs at home such as infidelity of wives, or health, or economic status of mothers or wives, (3) gradual onset of same symptoms after being long periods overseas in unpleasant and uncomfortable surroundings with only male companionship.

Many of these patients, of course, had a definite previous history of neurotic pattern and a large percentage had definite histories of intermittent ulcer symptoms previous to onset of their present acute illness.

PHYSICAL EXAMINATION

The findings on physical examination also were identical and consistent, in the two groups and only varied in degree. The patient was usually considerably underweight and tired, but not toxic in appearance. He was rather tense with either mild anxiety signs, such as only a fine tremor of hands and diaphoresis of palms, or in addition, more marked signs and symptoms of anxiety such as "startle reaction," insomnia, hyper-ventilation, stuttering and violent dreams.

All of these cases on admission had tenderness in the mid or right epigastrium on deep palpation, which also varied somewhat in degree depending on the acuteness of the ulcer.

Other physical findings were usually irrelevant.

LABORATORY EXAMINATIONS

The patients all were given routine laboratory examinations consisting of complete blood counts, routine urinalysis, blood Kahn test, and in addition, sedimentation rate, gastric analysis, and stool examinations for occult blood. In patients who had been stationed on island bases in the Pacific, examination of stools for ova and parasites was also routine.

X-RAY EXAMINATION

All of these patients had a routine gastro-intestinal x-ray examination on admission to this hospital. Most of them had had at least one previous examination, done soon after development of symptoms. As noted from the above figures, approximately one-half of the early examinations were reported as negative. In reviewing the histories, it was noted that a definite time relationship existed between the onset of symptoms and the appearance of a definite "niche" on x-ray examination.

One of us had an opportunity to observe early cases at a Guadalcanal mobile hospital, where approximately 5 per cent of gastro-intestinal x-ray examinations revealed duodenal ulceration. When seen at a later stage at this hospital, approximately 50 per cent of patients with the previously mentioned syndrome, revealed definite peptic ulcers.

This series of patients afforded an excellent opportunity to study the x-ray findings in the various stages of duodenal ulceration.

The usual fluoroscopic and radiographic examinations were carried out. The fluoroscopic examination was done as rapidly as practicable. Radiographs were relied on for fine detail. Spot films were of some value, but not indispensable.

We found it convenient and desirable to classify the disease into the following states: (1) acute, (2) subacute, and (3) healing. The x-ray findings were rather characteristic for each stage. However, the size and location of the crater modified the picture considerably.

ACUTE STAGE

A spasticity or irritability of the duodenal bulb was the principal finding during this period. Fluoroscopically, it revealed itself as a rapid intermittent emptying of the bulb followed by a spastic constriction at the ulcer site and distally; and a partial, sharply-cut off retention in the base. We often referred to this as the "turtle head effect."

Radiographs also revealed the spasticity, Fig. 1.

Pylorospasm was usually present, especially if the lesion approximated the pyloric valve.

An actual crater was seldom seen.

SUB-ACUTE STAGE

The crater or "niche" was usually found at this stage, Fig. 2. A varying degree of induration of the duodenal wall, at and around the ulcer site, was also evident.

The spasticity was less evident than in the acute phase. Fluoroscopically it revealed itself as a hypermotility of the bulb, radiographically as a spastic indentation, Fig. 2.

HEALING STAGE

The residual induration, and possibly a shallow depression at the ulcer site were the characteristic findings, Fig. 3.

Occasionally, hypermotility of the bulb was evident on the fluoroscopic screen.

METHOD OF TREATMENT

Since most of our patients had received some degree of treatment at advanced hospitals or on ships, the majority were in a subacute stage on entry. Our routine treatment consisted of:

(1) a. Bland diet with milk between meals and at bedtime.

(2) b. Tincture of Belladonna, drops 10 TID AC.

c. Phenobarbital, grs. ½ TID PC.

d. Aluminum hydroxide drams 2 prn., only if the above diet and medication did not relieve the epigastric symptoms. (After the first 7-10 days this was rarely required.)

(3) Psychotherapy: At the original examination and thereafter, every effort was made to determine through a psycho-somatic type of history what the principle precipitating factor was that caused the acute anxiety in the present illness. When this was obtained, it was pointed out to the patient that emotional stresses and strains could have a bearing on his epigastric symptoms. We gave a brief physiological explanation of the pathway of the emotional impulses through the mid brain, and the autonomic nervous system causing pylorospasm, hyperacidity and duodenal irritability. It was then pointed out that if the process continued over a long period of time, ulceration of the mucous membrane often resulted.

It was found that these acute precipitating factors, as noted above, fell largely into three groups. Most of the patients had a definite history of neurotic pattern since childhood, but our therapy because of the volume of patients and urgencies of war, was aimed mainly at the immediate rather than the deeper causes of the acute anxiety.

If the acute anxiety was precipitated by actual combat conditions, or being overseas in the combat area, the patient was assured, once his diagnosis was definitely confirmed, that he would never again be sent overseas. Furthermore, because of the type of illness he suffered from, he was told he would be surveyed after sufficient treatment, to either limited duty within the United States, or completely surveyed from the navy or marine corps.

If the acute anxiety was precipitated by family situations; which most of these men found were practically impossible to solve while overseas, the patient was encouraged to make a decision with regard to the problem and take some form of action upon it. A high percentage of the patients, for example, learned of infidelity of their wives while overseas or their wives wrote, stating they wished to be divorced. In these cases, the men were encouraged to bring their families or wives to the neighborhood of the hospital to solve their problems. Most patients were given liberty twice weekly, once their epigastric symptoms had subsided so that these matters could be adjusted or decided upon.

Under the above system of therapy, both anxiety symptoms and ulcer symptoms subsided rather rapidly. In most patients, epigastric symptoms subsided in a few weeks and radiologically the ulcer was healed in 6-12 weeks, at which time the patient was surveyed. It was observed that the healing of the ulcer radiologically usually coincided with the disappearance of the usual anxiety signs. The patient who had the most marked anxiety of all this group of patients, was the slowest to show healing of the ulcer radiologically—(five and one-half months).

All patients were ambulatory during the above therapy except in rare instances where epigastric symptoms were severe—in which case, bed rest was also given for a few days.

SUMMARY

One hundred and sixty-one patients were treated over a period of 13 months for duodenal ulcer. Eighty-three patients had a diagnosis of ulcer established by x-ray before entry. Seventy-eight of the group entered the hospital with a diagnosis of anxiety neurosis or combat or operational fatigue, and were found to have concurrent duodenal ulcers. All of the patients of both groups had a definite history of an acute anxiety state, plus epigastric complaints for usually several weeks or months preceding the time that the organic lesion could be demonstrated radiologically. If other psycho-somatic complaints were more prominent than the epigastric complaints, these patients were classified as anxiety neurosis at advanced bases. On the other hand, if the epigastric complaints were the most constant and x-ray examination revealed a definite ulcer, the anxiety state was ignored and duodenal ulcer became the diagnosis. X-ray examinations of the upper gastro-intestinal tract in the first few weeks or month of this syndrome do not as a rule reveal the organic lesion, but 1-2 months later if the anxiety state persists, the ulcer can usually be demonstrated radiologically.

These patients uniformly responded rapidly to therapy consisting essentially of bland diet and psycho-therapy aimed at the cause of the acute anxiety.

A schematic table (Table 1) correlating the neuropsychiatric, epigastric, and x-ray findings in the various stages of the syndrome is presented. Typical x-ray findings at various stages of this syndrome are also presented.

CONCLUSIONS

1. It is suggested that an underlying anxiety neurosis is a major factor in the etiology of duodenal ulcers. Stimuli due to emotional tension and strain transmitted through the hypo-thalamus and autonomic nervous system cause chronic pylorospasm, hyperacidity and duodenal irritability. This undoubtedly lowers the resistance of the duodenal mucosa with resulting erosion.

2. It is realized that all patients with an anxiety neurosis do not develop duodenal ulcers, many instead develop other somatic complaints such as effort syndrome and hypertension. However, all of the patients in the above series had an underlying anxiety state of some degree previous to the development of the organic lesion. The somatic manifestations which develop in patients with a chronic anxiety state are undoubtedly determined by previous early environmental influences.

Psychotherapy directed at the precipitating cause of the underlying acute anxiety state in this syndrome is of major importance in its treatment.*

U. S. Naval Hospital, San Leandro.

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* The authors wish to express their sincere appreciation to the following members of the psychiatric staff of the U. S. Naval Hospital, San Leandro, California, for their invaluable consultations and suggestions in this study: Capt. L. R. Gowan (MC), U.S.N.R., Comdr. Edson H. Steele (MC), U.S.N.R., Comdr. Joel Hill (MC), U.S.N.R., Comdr. William B. Titley (MC), U.S.N.R., Comdr. Kenneth Kelley (MC), U.S.N.R., and Lieut. Comdr. Carl A. Tillman (MC), U.S.N.R.

POLLINOSIS IN IMPERIAL COUNTY, CALIFORNIA, AND YUMA, ARIZONA*

WITH GUIDE TO TREATMENT

George F. Harsh, M. D.
San Diego

IMPERIAL County, California, is approximately the size of the state of Connecticut. Yuma, Arizona, and Mexicali, Mexico, although outside its political boundaries, adjoin Imperial County communities and are therefore included in this study. The pre-war population of this combined area was about 120,000. Most of the Colorado desert lies within Imperial County. The flat central portion of this desert, often called Imperial Valley, has been converted into a rich farming country by irrigation. Most of Imperial Valley is below sea level, reaching —244 feet at the Salton Sea. Mountains almost completely surround the valley, those to the west rising as high as 6,500 feet. Intense heat prevails throughout the summer and freezing temperatures occasionally occur in winter. The mean annual rainfall is 2.5 inches although great variations, from literally 0 to 8 or 10 inches, occur from year to year. The prevailing wind is westerly about 70 per cent of the time. High winds with accompanying dust storms are frequent. The relative humidity is low and, contrary to popular belief, is but little affected by the irrigation.

The incidence of pollen disease is high in this area. Although the concentration of pollen in the air never reaches the high values which obtain at the peak of the ragweed season in the middle west, this mitigating circumstance is more than offset by the length of the season and the rarity of even brief periods of respite due to rains, frosts, or favorable shifts in the wind.

Three decades of clinical trial by physicians in many countries have demonstrated the feasibility of specific hyposensitization therapy in pollinosis. Therapeutic success depends most of all on the proper selection of the constituents of the antigen to be used and this depends in turn on exact knowledge concerning the relative abundance in the air of the pollens of the various species to which the patient is exposed. Daily pollen counts at suitable locations give us valuable information concerning the concentration of pollen in the air. Unfortunately, only a few individual species of pollen can be identified microscopically; for the most part only families or genera can be identified in this way. The relative abundance and distribution of the various species of plants within these families or genera can be determined only by field observations repeated at frequent intervals throughout the year. The pollen production per given area can be quantitatively measured for each species and the buoyancy of the pollen and hence its ability to travel in the air can be estimated by determining the size and other physical characteristics of the pollen granules. The toxicity for any given patient is determined by skin testing. It was with all these factors in mind that the present study was planned.

An excellent survey for all of Southern California was published by Piness, Miller and McMinn in 1926.[1] However, in covering this vast area an intensive study of Imperial Valley alone was not to be expected. Moreover, the usefulness of their survey was limited by the fact that they reported only the "importance" of each species and did not show how this estimate was determined. Very important species such as Russian thistle (*Salsola kali*) have become abundant in Imperial Valley since their survey. A few important species, notably desert false ragweed (*Franseria dumosa*) were overlooked.

PROCEDURE

Daily pollen counts were made throughout the year 1936 from slides exposed on the roof of a two-story office building in the center of the business district of El Centro. Graphs of these pollen counts are shown in Chart I. The values expressed represent the numbers of each type of pollen grain found on one square inch of slide after a 24-hour exposure in a horizontal position. The slides were coated with the emulsion recommended by Wodehouse.[2]

Next it was necessary to determine the relative abundance and distribution of each wind-pollinated species which might be of importance in pollen disease in this area. For a period of two years, each community in Imperial County as well as Yuma, Arizona, and Mexicali, Mexico, was visited on the average of once every two months and careful notes and quantitative estimates made of the relative abundance of each species. In addition careful consideration was given to the occurrence of the various species of plants in the areas intervening between communities. The relative abundance on a scale of 1 to 10 of each species in Imperial Valley, and separately for Yuma and surrounding territory, is shown in Table I.

Other pertinent data necessary for arriving at an accurate notion of the significance of each species is also included in Table I. The pollinating dates given are the result of actual field observations. It must be remembered, however, that these dates are variable from year to year depending chiefly on the occurrence of rains. The values for pollen production are based on the arbitrary selection of *Franseria acanthicarpa* (false ragweed) as the standard with a value of 100. This plant was selected because it closely resembles *Ambrosia elatior* (dwarf ragweed) which has been used as the standard of comparison in similar studies by other authors. In the study of Barrett[3] both species were observed and by a similar method he arrived at a value of 65 for *Franseria acanthicarpa* as compared to 100 for *Ambrosia elatior*. To determine these values the flowering portions of the plants were gathered at the peak of the pollinating season from a pure stand of an area carefully measured or estimated to be 1 square meter in size, or some definite fraction or multiple of that area. These plants were then placed in water in the sun in a quiet room with the flowers hanging over glazed paper. After 48 hours the heads were shaken and dry pollen collected and weighed. The weight of pollen calculated for 1 square meter was then related to similar values obtained for our arbitrary standard. *Franseria acanthicarpa* was found to produce 1.7 gms. of pollen per square meter per day at the peak of pollination. For a few species the actual weight of pollen per square meter was not obtained. For these an estimate based on field observations is given on a scale of 1 to 4 plus.

The size of the pollen grain in the dry state was obtained by actual measurement.

The percentage of patients reacting by scratch test is also shown in Table I. This will be helpful to the practitioner in selecting the pollens to use for testing. It will be noted that certain species rarely give strong reactions whereas with other species, the stronger reactions predominate.

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* Author wishes to acknowledge the technical assistance of Mrs. Helen McMichael.

From the Rees-Stealy Clinic, San Diego.

* We wish to express our grateful appreciation to Dr. Philip Hodgkin of El Centro whose coöperation in exposing slides for pollen counts, made this study possible.

* The reprints of this article will contain a map of Imperial County and a table which shows the distribution of the plants of importance in pollinosis in this area. Additional data which could not be presented in tabular form are also given in reprints.

In the last column in Table I an attempt was made to indicate the over-all importance of each species.* Toxicity was disregarded in this estimate since that factor varies with each patient and is determined by skin testing. The values given were determined by the following formula:

$$\frac{n}{2} \cdot b \cdot p \cdot \frac{a}{10} = \text{I.R.}$$

when

n = number of months of pollination

b = buoyancy factor, which is equal to $\dfrac{\text{velocity of fall of a pollen of 25 microns diameter*}}{\text{velocity of fall of a pollen of the size in question}}$

p = pollen production (*Franseria acanthicarpa*) = 100 = 1.7 gms. per day per square meter

a = abundance (scale 1 to 10)

IR = Importance rating.

The theoretical considerations pertaining to this formula are discussed more fully in a previous communication.[5]

DISCUSSION

We may now refer back to Chart 1 and Table 1 and explain certain facts therein. The values for *Cupressaceae* are due almost entirely to *Juniperus californica* (juniper), which is found on the eastern slope of the Coast Range. The *Fagaceae* pollen must have come largely from *Quercus agrifolia* (coast live oak) and to a lesser extent from *Quercus chysolepis* (maul oak) which grow nearest to Imperial Valley in the mountains to the west. The values for "other compositae" must be due chiefly to *Pluchea sericea* (arrowweed) since the rise in the curve occurs during its flowering period. The *Artemisia* (sage brush) curve corresponds to the pollinating period of *Artemisia tridentata* (common sagebrush) which is found on the eastern slope of the mountains to the west. There are two rises in the *Ambrosia* (ragweed) curve, one due to *Franseria dumosa* (desert false ragweed) in May and June, and another in August, September, and October, which must be due to *Ambrosia psilostachya* (western ragweed) which grows throughout San Diego County to the west and to *Franseria acanthicarpa* (false ragweed) which lines the roadsides in the eastern third of San Diego County. The slight rise in March is probably due to *Hymenoclea salsola* (burrobush). It will be seen that grass pollen (*graminae*) occurs throughout the year, with a marked increase in April and May. Bermuda grass far exceeds all others combined.

We come finally to the most abundant group of all, the Chenopods and Amaranths. There is a slight rise in late January which comes from *Atriplex hymenelytra* (desert holly). A later rise in April and May can be accounted for only by *Chenopodium murale* (sowbane) and some early flowering *Amaranthus palmeri* (careless weed). The great rise in August and September is a composite of all the remaining members of this group, the chief of which is *Atriplex lentiformis* (quail bush).

SUMMARY

Pollen counts and data concerning the abundance, pollinating dates, relative pollinating ability, size of pollen grains, and pollen toxicity of plants concerned in pollen disease in Imperial County, California, have been presented. It is suggested that in determining the composition of the pollen antigen for any given patient, the skin reactions be considered first in relation to the abundance of the reacting species and then in relation to the amount of pollen produced and its buoyancy as indicated by its pollen size. In this way an intelligent decision as to the percentage of each pollen to be included in the patient's antigen can be made and a much higher percentage of satisfactory clinical results achieved.

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SUBDURAL HYDROMA*

A CAUSE OF MORBIDITY AFTER HEAD INJURY

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SKEPTICISM and suspicion are rapidly being lifted from this condition which must now be accepted as a well-defined clinical entity. Those who have seen cases of subdural hydroma treated successfully are able to appreciate that a relatively thin layer of clear fluid between dura and arachnoid can result in dire intracranial disturbances which may cause permanent disability of severe degree.

The literature contains about thirty articles on the subject and the earlier authors are quoted repeatedly. The more complete reviews of the literature are provided by da Costa and Adson,[2] and by Wycis.[6] Extensive outlines of the clinical picture, means of diagnosis and treatment are presented by Naffziger,[4] Dandy,[3] da Costa and Adson and by Wycis. Peet,[5] offers a concise description of the clinical problem.

ESSENTIAL PICTURE

The essential picture is one of progressive or persistent intracranial disturbance after a head injury. In mild cases there may be headache with some evidence of local brain compression. Severe cases may even exhibit status epilepticus, acute mania, deep coma or complete hemiplegia. Most authors state that the clinical picture is the same as in cases of subdural hematoma.

The lesion may occur as a simple collection of clear, colorless or yellow fluid, it may have an enclosing membrane, it may be massive and occupy a large part of the cranial cavity,[1] or it may even be solidified.[1]

Help in establishing the diagnosis is afforded by finding increased spinal fluid pressure, improvement following spinal puncture, failure of subarachnoid space to fill normally in an encephalogram or slight shift of the ventricles to the opposite side. However most or all of these items may be absent and the surest way to prove or rule out a subdural hydroma is by inserting burr-holes in the skull. And any patient who is not progressing satisfactorily after a head injury must be suspected of having such a lesion.

CLINICAL MATERIAL

In the past seven years a total of fifty-one patients with subdural hydroma have been treated. The age varied between one day and fifty-five years. They are subdivided in Table 1.

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* The velocity of fall of pollen grains of different sizes is given by Dahl and Ellis.[4]

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TABLE 1.—*Cases of Subdural Hydroma*

Acute, following head injury	21
Chronic, with history of head injury	23
Accidental finding	7
Total	51

Those classified as acute have occurred during the primary illness after a head injury. In the chronic cases there has been an interval, usually of several months, between a head injury and the culmination of symptoms leading to neurosurgical consultation. Accidentally found were in cases suspected of having hydrocephalus, epilepsy due to a cortical scar, brain tumor or other abnormality and in the course of burr-holes for ventriculogram the subdural hydroma was encountered or an encephalogram revealed it.

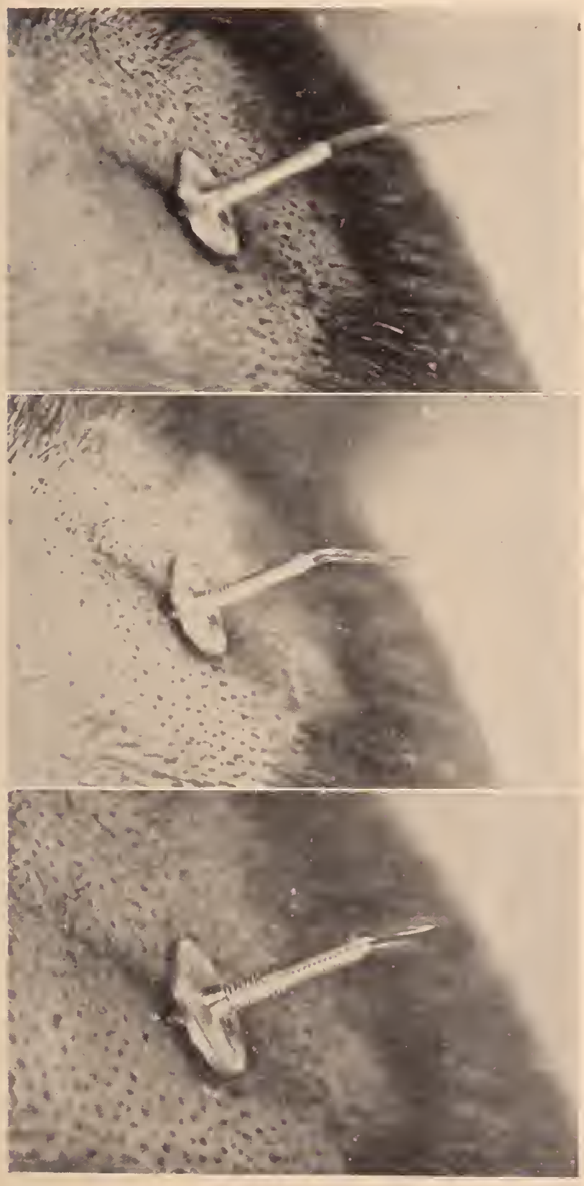

Fig. 1.—Case 1. Serial photographs taken with the blunt needle reaching through the dura. The top picture shows the sudden gush on first removing the stylette. Needle measures 1/16 inch outside diameter.

To review the mode of onset, outstanding symptoms, neurological signs and laboratory findings in all of the cases would be largely repetitious. A few points seem worthy of mention. All patients had some degree of headache, excluding small infants who were unable to complain. Babies usually gave evidence of discomfort in being irritable, holding the head or bumping it on the bed or wall. Headache was not necessarily the outstanding complaint and in some cases in which progressive attacks or increasing disability of an arm or leg was the presenting symptom, the complaint of headache was elicited only on direct questioning. (The patent, one day old, was in status epilepticus and had bilateral subdural collections. Now, at five months of age, she is apparently normal.)

In eleven depressed skull fractures of the "egg-shell" variety, seven had subdural hydromas. Three of the remaining four patients had torn dura. When subdural fluid was released in such cases the patient or the family usually noticed with surprise the prompt and general improvement and this was far out of proportion to what one would expect from raising a slight depression. It has come to be expected that, in this type of depressed skull fracture, a subdural accumulation of clear fluid will be found unless the dura is torn sufficiently to allow such fluid to escape. This provides an additional indication for elevation of depressed fractures even though the displacement of fragments may seem slight at the time x-rays are taken.

In the acute cases with focal symptoms it was sometimes surprising to see, for example, a completely paralyzed right arm with aphasia but much less weakness of the right leg, little effect on the level of consciousness and no significant change in pulse nor in blood-pressure. Thus, when a limited area of brain becomes affected to a severe degree, after a head injury, it speaks for a subdural hydroma rather than a hematoma. Also, when the effect was more generalized with such symptoms as acute mania or generalized headache with much vomiting, the level of consciousness was hardly altered. In the author's experience nausea and vomiting were more often found in cases of subdural hydroma than of subdural hematoma.

In many of the chronic cases, headache was present after a head injury but it subsided and more recently had become progressively worse. Slight neurological signs appeared to point to a one-sided lesion. Some of the cases were industrial and had been on compensation for between one and two years. It might be expected that this would lead to a functional overlay, beclouding the diagnosis. However a consistent story of headache, clearly described, usually unilateral, was accepted as genuine in spite of medico-legal proceedings. Confirmatory evidence was often found in one-sided attacks, larger pupil on the side of the lesion and slightly increased reflexes or sensory change on the side opposite to the lesion. When an encephalogram was carried out as a therapeutic measure for post-traumatic headache or for diagnosis in cases of epilepsy, the finding of subdural air was taken to indicate a subdural hydroma (Fig. 2). Such patients seemed to have much more headache and for a longer time after the air injection than did others without subdural air. Whenever subdural air was present in an encephalogram, burr-holes were inserted and subdural fluid was found. Drainage led to good improvement and almost always to complete relief.

REPORT OF CASES

Four cases are reported briefly to illustrate special points of interest.

CASE 1.—L. R., male, aged 42 years, referred by Dr. L. F. Smith of Monrovia, California, had been subject to right-sided convulsions without warning for nine months. On being asked directly, he reported having had headaches, in attacks, as long as he could remember. It was a dull, generalized headache and occurred most frequently, at least once per day, at puberty. It was becoming less frequent but not less severe. There was no history of a head injury before the onset of headache. Neurological examination revealed optic discs somewhat blurred in outline with small cups and dark retinal veins. The vessels curved slightly across the disc. Left pupil was larger than right. Sensation to pin was decreased on right face and arm. Right face moved 90 per cent voluntarily and 80 per cent with smile and scowl. Deep reflexes were stronger in right arm and leg than left. Perception of figures written on skin of right arm was definitely slow. The tentative diagnosis was neoplasm in left cerebral hemisphere but, when burr-holes were made for ventriculogram, a large bilateral subdural hydroma was drained. It was enclosed in a thin grayish membrane and the brain surface was between 5 and 10 mm. from dura. Large amounts of clear straw-colored fluid poured out. Drains were inserted through separate stab-wounds and dressings required changing once or twice daily, due to saturation with fluid. Drains were removed in four days. Then every five to seven days for the next five weeks, short brain needles were inserted to a depth of 2 cm. from the skin. With patient lying flat, fluid was allowed to drain until it stopped. On first withdrawing the stylette there would be a copious gush of fluid under high pressure (Fig. 1). On the last draining only 2 cc. of fluid came from the left side and less than 1 cc. from the right. Three months later patient reported no spells of any kind since the burr-holes. Headache was absent. Many of his friends had observed great change in his general attitude and alertness.

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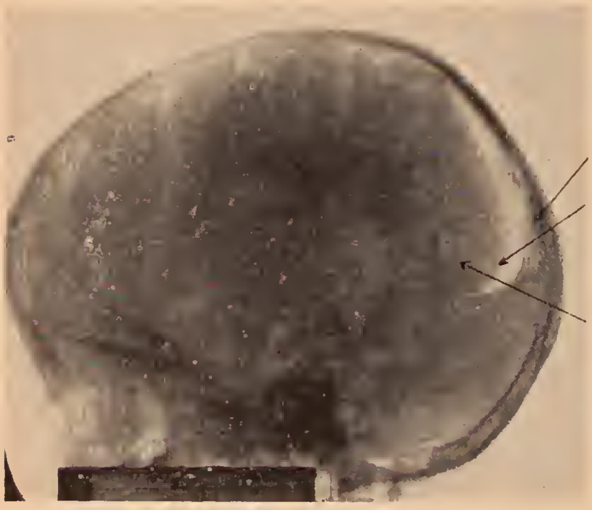


Fig. 2.—Case 3. Encephalogram, horizontal view, with brow down. Subarachnoid space is only moderately well filled. Outline of subdural air is indicated by arrows.

Case 2.—B. P., male, four months of age, referred by Dr. Milo Brooks of Westwood Village, California. The baby's head had been enlarging for three weeks. Was the second child and labor was apparently normal. The child had been born with a hare-lip and cleft palate and this had been repaired at the age of three months, or one week before the head had started to enlarge. Vomiting had begun and, following neurosurgical consultation elsewhere, the parents had been told that the condition was hopeless. The fontanelle was very tense and bulging, scalp veins were distended and blue. Maximum head circumference was 44.8 cm. Anterior fontanelle was 7.0 cm. wide. Burr-holes were inserted in both parietal regions and much clear yellow fluid drained from the subdural space. The fontanelle did not remain soft and eleven days later a left frontal burr-hole was made with additional copious drainage of fluid. Fontanelle again became tense and in four days a right frontal burr-hole delivered even more subdural fluid. In all burr-holes the brain surface was quite far from the dura and drains were left in for three days. The fontanelle became soft once more but fluid kept collecting under the right frontal scalp wound, causing it to bulge. This fluid was aspirated every two or three days, from 8 to 27 cc. being obtained at a time. As long as this fluid was withdrawn the anterior fontanelle remained soft. The baby was discharged and Dr. Brooks continued the aspirations every few days for three months. Seven months after operation baby was apparently normal. Head measured 51.0 cm. in circumference and anterior fontanelle was 3.5 cm. across.

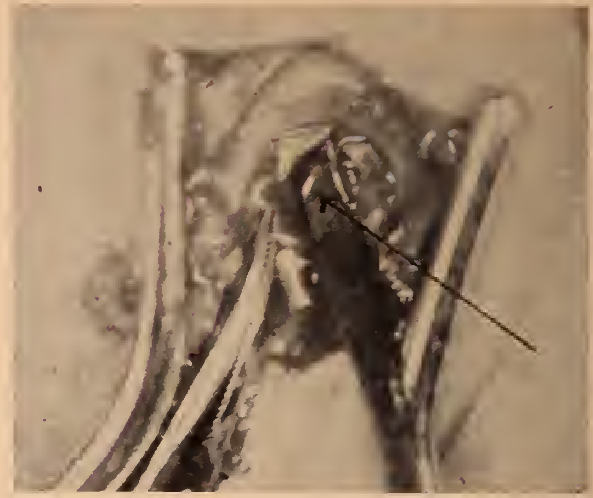


Fig. 3.—Case 3. Taken from color photograph of right parietal burr-hole after dura was opened. Small dissector is depressing brain from dura. Arrow points to clear fluid coming from subdural space.

* * *

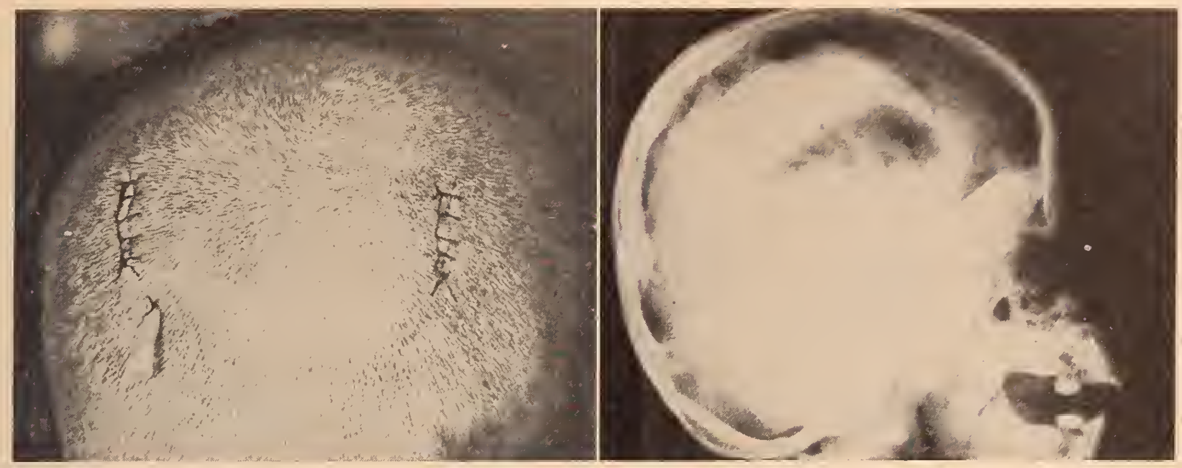
Case 3.—J. S., male, referred by the pediatric service, was seen first at the age of twenty months with the history of fifteen left-sided convulsions since birth. More recently there had been dragging of the left foot. Air encephalogram showed sulci slightly wider than average, normal ventricles, subdural air, (Fig. 2). Right parietal burr-hole released a large collection of fluid, (Fig. 3), on which total protein was 792 mg. per cent. Cerebro-spinal fluid total protein was 22.6 mg. per cent. Child improved but had right-sided convulsive manifestations and was readmitted for left parietal burr-hole with drainage of subdural hydroma of moderate size. In two weeks there were mild left-sided attacks again. Aspiration of right parietal burr-hole was unproductive and right frontal burr-hole was inserted. A large subdural hydroma was liberated and drainage was so profuse that the entire bed-linen required several changings. Drain was left in for four days. Two weeks later the right arm and leg were being used less than the left and a left frontal burr-hole was made, draining a subdural hydroma of moderate size. Three months later there had been no convulsive manifestations since the last operation and the other symptoms had disappeared.

* * *

Case 4.—M. V., female, referred by Dr. Milo Brooks of Westwood Village, California, aged two years. Was considerably retarded, not talking nor walking, using right arm poorly. Baby was irritable, would bump its head on the wall and eyes had been turned in since birth. Encephalogram showed ventricles large, left more than right and great enlargment of subdural space, (Fig. 4, b). For several days after the encephalogram baby was unusually restless with much vomiting. Bilateral parietal and frontal burr-holes were made and much clear yellow fluid obtained in all. Drains were left in the parietal regions for five days. After that, fluid collected under the scalp over right parietal burr-hole and every few days for a month it was aspirated in amounts up to 52 cc. Two years later the right parietal burr-hole was reopened and much fluid came away for several days. There had been definite improvement although baby was still very retarded.

COMMENT

As pointed out above, the diagnosis of subdural hydroma is suggested if there be neurological signs pointing to involvement of only a part of the hemisphere. Even when the disturbance is great, signs of increased intracranial pressure as reflected in level of consciousness, pulse-rate and blood-pressure, are lacking. As headache becomes more severe, it is accompanied by nausea and vomiting more often than in cases of subdural hema-



(a) (b)

Fig. 4.—(a) To illustrate the method of inserting a drain; (b) Case 4.—To show, in an encephalogram, an extreme degree of subdural hydroma diagnosed by subdural air.

toma. If an encephalogram has been carried out, headache with nausea and vomiting tends to be more persistent than usual.

When one visualizes the mechanism of an "egg-shell" variety of depressed skull fracture, it is easy to see how the arachnoid could be stretched and torn more readily than in the "closed" type of head injury.

In attempting to explain well-developed neurological signs resulting from a thin layer of subdural fluid, one should consider several factors. First the subarachnoid space beneath the hydroma is reduced in size with alterations in cerebrospinal fluid circulation there. Surface veins can be compressed, leading to congestion and edema in subjacent brain. Thrombosis can occur and might explain the tardy recovery of certain functions after an initial period of rapid improvement.

It is sometimes suggested that the finding of subdural fluid is due to an inadvertent opening in arachnoid when the burr-hole is inserted. Everyone doing neurological surgery knows that such fluid seeps through the arachnoid by drops and could not give rise to the continual flow of fluid from areas far beyond the opening in the dura.

Some authors advise against leaving drains in place when subdural fluid is encountered. It is the author's experience that, when rubber tubing drains are inserted through separate stab-wounds (Fig. 4, a) they may be left in for at least five days without complication.

It is illustrated in the cases outlined above that repeated drainage or insertion of multiple burr-holes may be necessary for a satisfactory result. The operation of making burr-holes in the skull is not a serious one and carries a negligible degree of risk. It is often done as a diagnostic measure and should not be withheld until there is no doubt about the necessity of draining a subdural collection.

Almost all of the patients who have had subdural hydoma drained adequately, have shown lasting improvement amounting to complete cure. Recovery has usually taken place in from a few days to three or four months. Babies with much mental retardation and who had large subdural collections showed some improvement. One might surmise that earlier operation would have been more effective.

SUMMARY

The primary description of the clinical problem of subdural hydroma has been covered by many authors.

Any patient who has persistent or progressive intracranial disturbance after a head injury may have such a lesion.

The neurological symptoms and signs may be slight or severe.

Subdural hydroma has been found in cases of depressed skull fracture of the "egg-shell" variety.

Improvement is usually prompt with, in most coses, complete recovery when the hydroma is drained completely.

Fifty-one cases have been treated by the author. Significant details are recorded in four cases in which repeated drainage was necessary.

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Edward Jenner (1749-1823).—The boy Jenner was bled, purged, and dieted for six weeks preparatory to smallpox inoculation. This horrible experience was never forgotten; nor, as a medical student, did Jenner fail to recall a milkmaid's remark: "I cannot take smallpox, for I have had cowpox." After years of study, on May 14, 1796, Jenner inoculated eight-year-old James Phipps with matter from the cowpox vesicles on the hands of Sarah Nelmes. Subsequent smallpox inoculation proved him immune. Thus began immunology.—Warner's *Calendar of Medical History.*

Karl A. Rudolphi (1771-1832).—The great honors bestowed upon the Swedish naturalist, Karl A. Rudolphi, were well deserved for under his guidance Berlin began to develop into a great center for the study of human and comparative anatomy. Aside from this, he has been called the father of helminthology and the Linnaeus of parsitology because of the many new species which he described. Apparently, he was the first to see Taenia echinococcus.—Warner's *Calendar of Medical History.*

CHRONIC LEG ULCERS OF SICKLE CELL ANEMIA*

REPORT OF CASE: WITH REFERENCE TO RECOGNITION OF THE DISEASE IN CALIFORNIA

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AND
SAMUEL TASKER, M. D.
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SINCE Herrick's first report in 1910[1] of sickle cell anemia associated with leg ulcers, over three hundred cases of the disease have been reported in the medical literature.[2] No instances of the disorder, however, have been reported to date from California or other Pacific coast states. It is probable that the relatively small Negro population in this State previous to 1940 compared to the southern United States, where most cases have been reported, has presented little or no opportunity for California physicians to encounter this disease. The marked increase in the Negro population in California during the past five years, due to employment offered by war and industrial plants, has more than doubled the Negro population in the State. Most of these Negroes have migrated from southern states where the disease is relatively common. The fact that chronic leg ulcers is one of the cardinal signs in active cases of sickle cell anemia especially warrants the recognition of these skin lesions by California physicians. These ulcers closely resemble those on the leg due to syphilis, tuberculosis, circulatory stasis, and trauma. Practitioners who do not keep in mind the possible diagnosis of sickle cell anemia when examining a Negro with the complaint of leg ulcer may therefore miss the true diagnosis. If the patient is employed in an industrial plant, the problem of compensation insurance for disability caused by these ulcers may arise and the importance of a correct differential diagnosis is evident. It is the purpose of this article to call attention to the leg ulcers of sickle cell anemia by reporting a case occurring in Southern California so that physicians in the State may be on the alert for the recognition of this disease.

REPORT OF CASE

Mrs. G. D., a Negress, aged 23, was first seen on March 26, 1945, because of chronic ulcers on the lower legs. Her history revealed that the lesions first appeared in January, 1944, as small, painless, "pimples" on the ankle that gradually enlarged, opened, and formed deep ulcers. These ulcers were indolent and resisted all types of local treatment for seven months before healing. Thin atrophic pigmented scars with surrounding hyperpimentation remained at the sites of the healed lesions. In January, 1945, ulcerated areas again appeared on the ankles and lower legs. The past history revealed that the patient had suffered from marked weakness and fatigue for five years that prevented her from performing heavy work. She also suffered from intermittent attacks of severe epigastric pain associated with nausea and vomiting. No other members of her family had a history of leg ulcers.

The *physical examination* revealed a thin undernourished Negress of average height with yellowish sclerae. The examination of the heart showed this organ to be enlarged. There was a soft blowing systolic murmur at the Apex. The blood pressure was 124 systolic and 70 disatolic. The examination of the abdomen showed the spleen to be enlarged and palpable 2 cm. below the left costal margin. Over the lower anterior third of the left leg was a large atrophic scar. A silver dollar-sized punched out ulcer was on the external malleolus. The ulcer was 1 cm. deep and had a suppurative granulating base. The border of the ulcer was raised and hyperpigmented. On the right lower leg were two similar palm-sized punched out ulcers on the internal and external malleoli. There was no evidence of varicose veins or circulatory stasis.

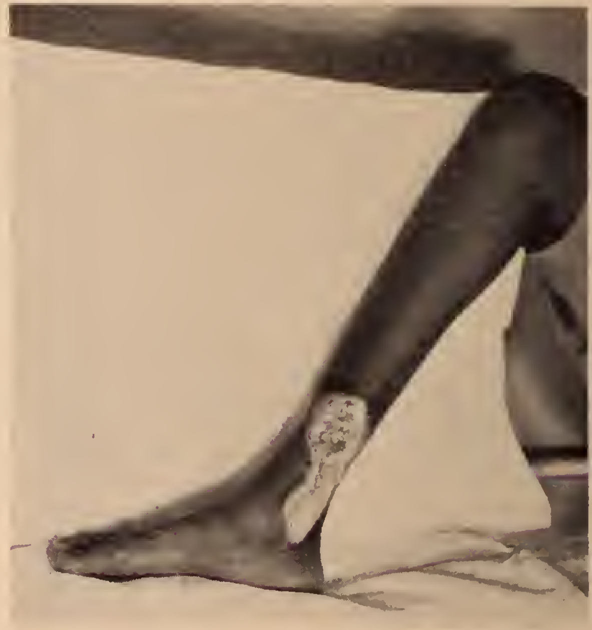

Fig. 1.—Large ulcer of sickle cell anemia on right lower leg.

The *serologic examination* of the blood for syphilis was negative. The blood count showed: haemoglobin, 50 per cent; erythrocytes, 2,800,000; color index, .88; leucocytes, 15,250; neutrophiles, 67.5 per cent; lymphocytes, 25 per cent; monocytes, 7.5 per cent. The examination of the blood smear showed one nucleated red blood cell, a few macrocytes, and a moderate number of sickle cells. A few erythrocytes showed a moderate degree of polychromasia. The platelets appeared normal in number. The icteric index was 21. The urinalysis was normal except for the presence of urobilin. The stool examination was negative for ova and parasites. The histologic examination of a biopsy specimen taken from the edge of a leg

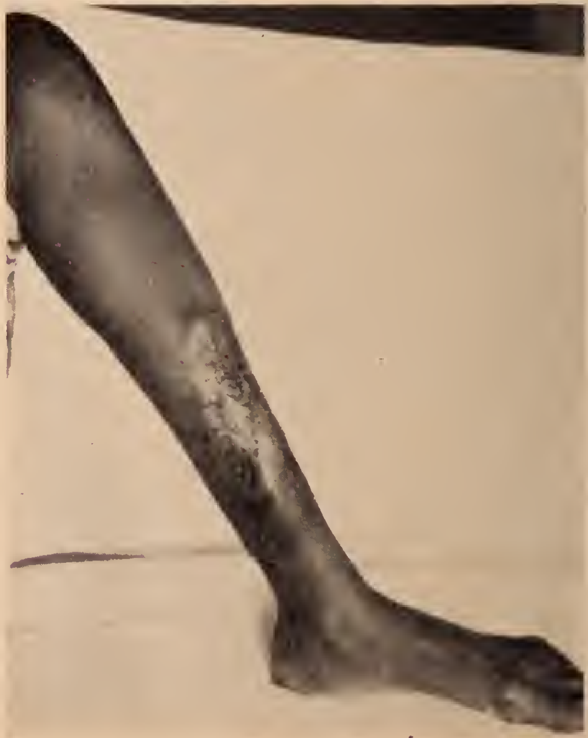

Fig. 2.—Atrophic pigmented scar of healed ulcer of sickle cell anemia on left leg.

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* From the Department of Dermatology of the University of Southern California Medical School.

ulcer showed a chronic nonspecific granuloma. There was no microscopic evidence of tuberculosis or syphilis. Cultures taken from the ulcer innoculated on Sabauraud's medium showed no growth of coccidioides. Cultures of streptococci and staphylococci grew on innoculated agar media. The Roentgen examination of the heart and lungs showed the heart to be enlarged to the right and left of the midline. There was no evidence of pulmonary or glandular tuberculosis.

The *treatment* consisted of rest and the oral and intramuscular administration of crude liver extract and iron. All types of local therapy were used for the ulcers without success. The ulcers remained treatment resistant, indolent, and healed slowly leaving residual atrophic pigmented scars.

COMMENT

Sickle cell anemia is hemolytic anemia found almost exclusively in the colored race. Eight authentic cases of white patients suffering from the disease have been reported,[3, 4] although four of these were of mediterranean stock. Except for a few cases reported from northern Africa,[5] almost all the patients have been reported from the southern United States. The disease is familial and hereditary and is transmitted as a dominant trait by either sex by the Mendelian law of heredity.[6] Sickelemia or the sickle cell trait is present in 7 to 8 per cent of healthy Negroes. The sickle cell trait is apparently not harmless as about 1 out of 40 Negroes with sickled erythrocytes have been reported to show evidence of sickle cell anemia and chronic leg ulcers.[7] The sexes are involved to an equal degree. The age of appearance of the leg ulcers varies from early childhood[8] to late adult life[9] with an average age being 15 years.[10] The leg ulcers usually develop in all patients showing a marked anemia although they may be present in latent and remission stages of the anemia. Patients with leg ulcers seen during the latent or remission stage of sickle cell anemia may present a difficult diagnostic problem. The anemia, however, presents constitutional symptoms involving the cardiovascular,[11] osseous,[12] and nervous,[13] systems that must be evaluated in making a diagnosis in all cases where the blood findings are normal during a remission. Repeated search for sickled red blood is often necessary before the true diagnosis of the leg ulcers can be established.[14]

The *blood findings in patients with sickle cell anemia* leg ulcers are those of a hemolytic anemia plus the cardinal finding of sickling of red blood cells.[15] Crenated and elongated red blood cells may also be present but true sickling of erythrocytes must be found for diagnosis. The anemia is usually well marked with a count of 1 to 2 million erythrocytes and 30 to 60 per cent hemoglobin. Leucocytosis of 10 to 30 thousand is usual with an average count of 18,000. The blood platelets are increased from 300 to 500 thousand. The resistance of the red blood corpuscles to hypotonic saline solution is increased and an associated hyperbilirubenemia with an increased icteric index of 15-25 units is usually present.[16] The direct van den Bergh reaction is negative and the indirect is positive. Urobilin is present in the urine. The reticulocyte count is elevated, often to 25 per cent. The reticulocyte count percentage is increased or decreased with remissions and follows the curve of the increased red blood cells.[15] Diggs and Bibb[15] have shown that the use of wet preparations for the finding of sickling in the red blood cells requires 2-6 hours for maximal change in the erythrocytes and the sickling is complete in 12-24 hours. In active cases of sickle cell anemia the changes in the erythrocytes can be found in dried and stained blood smears. The latent cases can be diagnosed by the wet preparation method of placing a cover slip over a fresh drop of blood on a slide and sealing the edges with petrolatum. The percentage of red cells taking on a sickle appearance within 12-24 hours in wet preparations may be as high as 70 to 90 per cent. The sickling is believed to be caused by changes of the red cell wall or abnormal osmotic tension within the cell.[14] That the sickling is not caused by any peculiarity of the blood serum has been shown by placing normal red blood cells in serum from sickle cell anemia patients with the result that no sickle changes are noted.

The *leg ulcers of sickle cell anemia* are present in three out of four adolescent or adult patients afflicted with the active phase of the anemia.[10] The ulcers may antedate for years the constitutional symptoms of the disease, may be present in latent cases, or may appear subsequent to the appearance of the clinical symptoms of the anemia. The ulcers are not common in childhood although an 8-year-old child was reported by Anderson and Ware.[17] Ulcers and scars of healed ulcers are invariably present in patients seen in adolescence. The ankle is the most common site although the ulcers are frequently observed on various parts of the leg. In appearance, the ulcers are punched out, quarter size or larger, deep, and have a granulating and suppurative base. The resulting scar is atrophic, pliable, glossy, with a pigmented areola and resembles the scar produced by syphilis. The ulcers in all cases have proved to be chronic, indolent and resistant to all known treatment with a tendency to heal slowly in a period of three months to one year.

DIAGNOSIS

The diagnosis of sickle cell anemia based solely on the clinical or pathologic appearance of the leg ulcers is difficult. The diagnosis must be made by examination of the blood for evidence of a hemolytic anemia and sickling of the red blood cells and from the associated constitutional findings. The diagnosis of sickle cell anemia must always be considered in adolescent and young adult Negroes who present nondescript leg ulcers that cannot be diagnosed any other disease. Because of their appearance, the diagnosis of these leg ulcers always involves the differentiation from ulcers on the legs caused by tuberculosis (erythema induratum and scrofuloderma), syphilis, circulatory stasis, congenital hemolytic jaundice, trauma, and, in California, coccidioidal granuloma. Erythema induratum ulcers occur chiefly on the calves of the legs in adolescent girls with a chilblain type of circulation. The ulcers are preceded by hard indurated bluish red plaques that later break down into suppurating ulcers. The histopathologic examination is diagnostic for the disease. Scrofuloderma produces ragged irregular ulcers at the site of discharging sinuses of underlying tuberculosis of the bone or joint. There is usually evidence of associated glandular or pulmonary tuberculosis. The morphologic characteristics of ulcers of tertiary syphilis are often indistinguishable from those of sickle cell anemia. The serologic examination of the blood and spinal fluid for syphilis and an examination of the blood for anemia and sickling will clarify the diagnosis although both diseases may be present. A therapeutic test with antisyphilitic therapy may be indicated before the true cause of such ulcers is evident. Circulatory stasis produces ulcers in older individuals usually in the third decade of life or later. The ulcers are associated with varicose veins and stasis manifestations. Congenital hemolytic jaundice may also cause leg ulcers. The marked splenic enlargement, absence of sickled red blood cells, and the lowered resistance of the erythrocytes to hypotonic salt solution will, however, readily differentiate this disease. Traumatic or pyogenic ulcers are usually rapidly responsive to antipyogenic therapy and avoidance of further truama. Coccidioides granuloma is an important disease to differentiate in California. Cultures for the fungus, animal innoculation, and the finding of the organisms in histologic sections readily differentiates this granuloma from the ulcers of sickle cell anemia.

ETIOLOGY

The etiology of leg ulcers in sickle cell anemia has not been determined. It is thought that the sickle cells form thrombi in the small capillaries of the leg with resulting poor nutrition of the overlying skin producing a breakdown and ulcer formation.[18] That the common areas of involvement are on the lower legs at points of trauma may also be a basis for the location of these ulcers. It is of interest that another hemolytic anemia, congenital hemolytic jaundice is also associated with a similar type of leg ulcer, but no sickling of the red blood cells is present in this disease.

The prognosis of sickle cell anemia ulcers is that of the underlying anemia. The lesions so far have proved to be resistant to all known therapy. They tend to heal slowly of their own accord and leave residual scars. Relapse and recurrence of these leg ulcers is usual and tend to follow the course of the anemia. The ultimate outcome of the leg ulcers is not usually known because most patients die early in life and few survive the third decade due to intercurrent infection.

SUMMARY AND CONCLUSIONS

1. A case of chronic leg ulcers due to sickle cell anemia occurring in Southern California is reported.

2. Due to the recent large increase in the Negro population in this State, the importance of recognition and diagnosis of these ulcers by California physicians is important.

3. Chronic sickle cell anemia leg ulcers may present compensation insurance problems to physicians examining Negroes in industrial and war plants.

4. The differential diagnosis of chronic sickle cell anemia leg ulcers is discussed.

5. The etiology and effective treatment of chronic sickle cell anemia leg ulcers is still unknown.

1930 Wilshire Boulevard.

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Victory for Preventive Medicine—European Epidemics Averted So Far

London (Assoc. Press).—UNRRA medical authorities say that Europe is ever the hump in the battle against disease and has a good chance of getting through the remaining critical winter months without a major epidemic.

If the optimism is borne out, a spokesman said, it will be a great tribute to preventive medicine in combating deplorable conditions that faced peacetime Europe—insufficient housing, disrupted public utilities and Spartan diet.

The nearest approach to an epidemic was in England at the end of January. Influenza deaths in 126 major cities used as a barometer jumped 99 in one week to a high of 273—a surprise, since trouble had been expected more from countries ravaged by belligerent armies.

Smallpox: None except in Italy, where from April, 1944, to January, 1946, there were 5,686 cases and low mortality. In December, the number waned to 58. Advanced state of vaccination throughout Europe responsible for minimizing disease.

Plague: None except in the Mediterranean ports. Jaffa has two cases; Haifa and Tel Aviv one each. Last summer a Corsican port had seven cases, five deaths. Malta had 75 cases and 19 deaths in the last six months of 1945. Taranto, Italy, had 30 cases and 15 deaths until November, but none since. Carried by rat fleas, plague usually occurs only in ports and is combated by immunization of incoming ships and rat killing drives.

Typhus: Situation satisfactory in Western and Northern Europe, although winter is peak season. Central Europe trend was upward in December but there is no cause for anxiety in view of control measures. In Balkans the situation is more satisfactory than anticipated except in Croatia and Romania. Mass inoculation cut down mortality. Romania, which had an epidemic last year, reports 500 cases a week. Poland, which averaged 3,500 cases annually before war, reports 130-140 weekly but it is not expected to get worse.

DDT powder has revolutionized control of typhus. In British and American zones in Germany, for example, an average of 1,000 cases weekly in June had dwindled by the end of August to practically none because of a campaign employing DDT.

Russia's wartime use of SK9—pyrenthum-base powder, compulsory baths, change of uniforms and strict control measures in liberated nations helped prevent expected typhus epidemics in Eastern Europe.

Diphtheria: Highest mortality rate of all diseases during the war—receding except in Netherlands, France and Germany. England and Wales, where immunization has continued since 1940, has the lowest mortality in history.

Scarlet Fever: Waning from wartime high of two to five times normal cases except in Sweden, which has two and a half times more cases than normal, and Denmark, three and a half times.

Typhoid Fever: Trend downward despite the fact that wrecked sewage and water supply systems make destroyed cities ripe for epidemic. Germany and Poland have only high incidence, the latter with 2,000 cases weekly in January, a drop since October high.

Tuberculosis: Worst in Italy, Yugoslavia and Greece, which had 25,000 deaths in 1945. A recent cross section test in Italy showed 2 to 4 per cent per thousand persons sampled had TB.

Venereal Diseases: Up three to nine times prewar figures; highest in Germany.—Los Angeles *Times.*

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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75TH ANNUAL SESSION

California Medical Association

AT LOS ANGELES

Tuesday, May 7 - Friday, May 10, 1946

Make note of these dates on your Calendar.

Scientific Programs and Official Reports will appear in this issue of C. and W. M.

The official headquarters of the next annual session of the California Medical Association to be held at Los Angeles, Tuesday, May 7 through Friday noon, May 10, 1946, will be the *Hotel Biltmore*, 515 South Olive Street (Olive, between Fifth and Sixth Streets), Los Angeles. Because of postwar conditions and prospective attendance, the facilities of other hotels must also be used.

All requests for reservations must be sent to the hotels direct. In writing, it is well to state the number in the party, date of arrival, date of departure, nature of accommodations desired (single room, double room, double bed, twin beds, bath).

LOS ANGELES HOTELS: WITH TELEPHONE NUMBERS

A list of some hotels in Los Angeles within easy distance of the Hotel Biltmore follows:

Hotels	*Telephones*
Alexandria Hotel, 210 W. Fifth St.	(MAdison 2741)
Ambassador Hotel, 3400 Wilshire Blvd.	(DRexel 7011)
BILTMORE HOTEL, 515 S. Olive	(MIchigan 1011)
Carlton Hotel, 519 S. Figueroa St.	(MIchigan 6571)
Chapman Park Hotel, 516 S. Alexandria Ave.	(FItzroy 1181)
Clark Hotel, 426 S. Hill St.	(MIchigan 4121)
Gates Hotel, 831 W. Sixth St.	(TRinity 3931)
Hayward Hotel, 206 W. Sixth St.	(MIchigan 5151)
Mayfair Hotel, 1256 W. Seventh St.	(FItzroy 4161)
Mayflower Hotel, 535 S. Grand Ave.	(MIchigan 1331)
San Carlos Hotel, 507 W. Fifth St.	(MUtual 2291)
Savoy Hotel, 601 W. Sixth St.	(MAdison 1411)
Stillwell Hotel, 838 S. Grand Ave.	(TRinity 1151)
Town House, 639 S. Commonwealth Ave.	(EXposition 1234)
William Penn Hotel, 2208 W. Eighth St.	(EXposition 3181)

A.M.A. Session

American Medical Association will hold its annual session this year in San Francisco. Dates: Monday, July 1 - Friday, July 5, 1946.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICES

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Thirtieth (330th) Meeting of the Council of the California Medical Association*

The meeting was called to order at 10:00 A.M., on Friday, February 1, 1946, at the Hotel Biltmore, Los Angeles.

1. **Roll Call:**

Councilors Present: Philip K. Gilman, Chairman; E. Vincent Askey, Sam J. McClendon, Edwin L. Bruck, Sidney J. Shipman, E. Earl Moody, Dewey R. Powell, Edward B. Dewey, Walter S. Cherry, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary.

Councilors Absent: Herbert A. Johnston (ill).

Present by Invitation: L. A. Alesen, Vice-Speaker; Dwight H. Murray, Chairman Committee on Public Policy and Legislation; Dwight L. Wilbur, Delegate to the A.M.A.; Chester L. Cooley, C.P.S. Secretary; John Hunton, Executive Secretary; W. M. Bowman, C.P.S. Executive Director; Howard Hassard, Associate Legal Counsel; Ben H. Read, Secretary, Public Health League of California; E. T. Remmen, Chairman, Local Committee on Arrangements, 1946 C.M.A. Meeting in Los Angeles; Stanley K. Cochems, Executive Secretary, Los Angeles County Medical Association; A. E. Hardison, Acting Medical Director, American Red Cross; Ralph W. Stearns, Klamath (Oregon) Medical Service Bureau; L. M. Spaulding, President, Oregon State Medical Society; A. E. Varden, Secretary, San Bernardino County Medical Society; Henry D. Neufeld, Secretary, Contra Costa County Medical Society; A. E. Moore, President, San Diego County Medical Society; Morton R. Gibbons, State Emergency Council; Louis J. Regan, President, Los Angeles County Medical Association; Rollen Waterson, Executive Secretary, Alameda County Medical Association; and Frank Kihm, Executive Secretary, San Francisco County Medical Society.

2. **Minutes:**

Minutes of the following meetings of the Council and Executive Committee were submitted and actions taken approved:

(a) Council Meeting (329th) held in Los Angeles on October 21, 1945. (Printed in California and Western Medicine, December, 1945, page 277.)

(b) Executive Committee Meeting (196th) held in San Francisco on November 16, 1945. (Printed in California and Western Medicine, January, 1946, page 33.)

3. **Membership:**

(a) A report of membership as of January 26, 1946, was submitted and placed on file. The membership roster showed distribution as follows:

Total members (civilian and military) listed for year 1946: 3,689.

Total members in military service: 1,726.

Total members returned from military service: 550.

(b) On motion made and seconded, Retired Membership was granted to the following members, whose applications had been received in accredited form from their county societies:

Orah Knapp Allen, San Francisco County
Edna M. Barber, Alameda County
Emil C. Black, San Diego County
John C. Condit, Alameda County
M. L. Fernandez, Contra Costa County
James K. Hamilton, Jr., Alameda County
Aden C. Hart, Sacramento County
Murrey L. Johnson, Alameda County
Marguerite D. Keser, Contra Costa County
Edwin D. Kilbourne, Santa Clara County
Frieda L. Kruse, San Francisco County
Henry Snure, Los Angeles County
William B. Stephens, Alameda County
Harry B. Torrey, Alameda County
Edwin W. Wayte, Los Angeles County
Alvin H. Wilmar, San Luis Obispo County

(c) On motion made and seconded, Life Membership was granted to the following members, whose applications had been received in accredited form from their county societies:

Fred Ross Fairchild, Yolo County
A. M. Henderson, Sacramento County

(d) On motion made and seconded, it was voted to reinstate 6 members whose 1945 dues had been paid subsequent to October 21, 1945.

(e) Report was made concerning the action taken by the Council Chairman in re: granting Associate Membership to school physicians.

(f) Report was made concerning a communication received from the Judicial Council of the American Medical Association in which it was stated that physicians having Retired Membership in the California Medical Association are not eligible for Fellowship in the American Medical Association.

4. **Financial:**

(a) A cash report as of January 26, 1946, was submitted.

(b) Digest of the Certified Public Accountant's report for the calendar year 1945 was presented.

(c) Report on collection of 1946 dues and dues of military members was submitted.

(d) Report was made by Doctor John W. Cline, Chairman of the C.M.A. Executive Committee that a draft of a budget had been prepared by the Auditing Committee and was under consideration by the Executive Committee, and that report thereon would be made by the Executive Committee at the next meeting of the Council.

(e) Attention was called to the lapse of time that occurred under the existing system in relation to the beginning of a fiscal year in which the budget adopted by the House of Delegates would become operative.

On motion by Doctor Cline, Chairman of the Auditing Committee, it was voted that the fiscal year should hereafter begin not on January 1st following a meeting of the House of Delegates, but on July 1st of any calendar year. (Refers to phraseology in Chapter IV, Section 5, of the by-laws regarding fiscal year.)

5. **Special Committee on Prepayment Plans and C.P.S.:**

For the Special Committee on Prepayment Plans and California Physicians' Service, Loren R. Chandler, M.D., Chairman, a progress report was made by Doctor Philip K. Gilman who had met with the above committee. It was stated that this special committee would have a meeting during the coming month with the Advisory Planning Committee at which time a report would be formulated for submittal to the Council. In the discussion, Doctors L. M. Spaulding, President of the Oregon State Medical Society; and Ralph W. Stearns, of the Klamath Medical Service Bureau, were asked to comment upon conditions they had met in their own plans.

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* Reports referred to in the minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

6. Committee on Postwar Planning:

Relative to a communication dated October 25, 1945, received from Harold A. Fletcher, California State Chairman for Procurement and Assignment Service for Physicians, presented in CALIFORNIA AND WESTERN MEDICINE for November, 1945, on page 228, and referred to in the minutes of the 329th Meeting of the C.M.A. Council as Item 9 (December, 1945, CALIFORNIA AND WESTERN MEDICINE, page 279), discussion was had concerning misinterpretations that had arisen in regard thereto.

After full discussion, the following resolution was adopted by the Council:

Resolved, That in view of public expressed inferences to the effect that the medical profession in California is in some manner opposing the location in the State of Physicians from other states or countries, the Council of the California Medical Association believes it appropriate to reiterate the fact that the privilege of practicing medicine in California is not dependent upon membership in a component county medical society or in the California Medical Association, but solely upon issuance of a license by the State Board of Medical Examiners, and that admission to membership in a component county medical society is exclusively governed by Chapter I, Section 4 of the California Medical Association by-laws, which reads as follows:

"Each component county shall . . . determine the qualifications for membership therein, and *shall be the sole judge* of the qualifications of applicants for such membership"; and be it

Further Resolved, That each county society be reminded that in passing upon applicants for membership it is the sole judge of each applicant's qualifications and that it should consider each applicant separately and on his own merits and reach its decision upon the basis of the applicant's qualifications or lack thereof; and be it

Further Resolved, That a copy of this resolution be sent to each component county medical society.

7. California Physicians' Service:

Doctor Chester L. Cooley, Secretary of the Board of Trustees of California Physicians' Service, gave an oral report on recent happenings. Recently, Doctor Cooley and Mr. W. M. Bowman went to Montana to aid the Montana State Medical Association in its efforts to institute a prepayment medical service plan, modeled somewhat after "California Physicians' Service." C.P.S. loaned to the Montana organization their form blanks. C.P.S. will also send an experienced worker to aid Montana in starting its organization.

It was stated that New Mexico, Arizona and Nevada were likewise interested. If plans matured, it was possible that a regional prepayment medical care organization might come into being.

The Council was told that C.P.S. affiliations in Sacramento had improved and that the number of professional members was steadily increasing.

Mr. Bowman reported upon the financial conditions of C.P.S., outlining reasons why expenses were heavier in certain months.

The significance of the new contract between Veterans' Administration and C.P.S. was outlined. V.A. has sent Colonel Wright to California to become the liasion officer in this work.

8. Committee on Public Policy and Legislation:

Doctor Dwight H. Murray, Chairman of the Committee on Public Policy and Legislation, submitted two reports: (a) Report as Chairman of the California delegation to the A.M.A. House of Delegates; and (b) Report on the status of pending medical legislation.

(a) Doctor Murray made report concerning the resolutions introduced by California Delegates at the Chicago meeting of the A.M.A. House of Delegates held on December 3-6, 1945. (These resolutions appear in *J.A.M.A.*, December 15, 1945, and December 22, 1945, and also in CALIFORNIA AND WESTERN MEDICINE, January, 1946, pages 37-39.)

Reference was also made to the important address by General Paul R. Hawley, Medical Director of the Veterans' Administration.

It was stated that in Chicago three plans of prepayment groups were outlined; Doctor Murray stating that the A.M.A. Trustees would consider these at their meeting in February, in an effort to formulate a national policy with possible formation of a federation of prepayment groups.

Associate Legal Counsel Hassard also made comment concerning a national policy and plan, with emphasis that the administration be a local basis. The possibility of regional groups being developed was also mentioned and the value of an advisory service, so that prepayment groups still to come into existence might avail themselves of the experiences of pioneer service organizations.

The Council favored the general policies indicated, as outlined, by Doctor Murray and Mr. Hassard.

9. American Red Cross: Blood Procurement Facilities:

Doctor A. E. Hardison, Acting Regional Medical Director of the American Red Cross, spoke to the Council concerning plans being formed in regard to blood donor service and blood procurement for civilians and the civilian plasma program.

It was stated the California State Board of Public Health, through local officers and affiliated groups and physicians, will make available in civilian practice dried blood plasma that had been accumulated by the American Red Cross. (Information concerning this appears in CALIFORNIA AND WESTERN MEDICINE for January, 1946, on page 5.)

The California State Board of Public Health has announced it will send information concerning procedures to be followed in securing such blood plasma, to local health officers, hospitals, and affiliated institutions.

Discussion took place concerning endorsement of a plan. Because the details had not been worked out at the present time, it was voted to refer the proposal on how the Red Cross will continue procurement of blood for civilians, to a special committee to be appointed by the Council Chairman. Doctors Edwin L. Bruck, Lloyd E. Kindall, and John W. Green were appointed.

10. A.M.A. Annual Session in San Francisco in 1946:

Doctor John W. Cline, who had been nominated to the A.M.A. Trustees by the San Francisco County Medical Society to act as Chairman of the Local Committee on Arrangements for the 1946 A.M.A. meeting in San Francisco, made report on the tentative plans for the A.M.A. meeting to be held Monday, July 1st, through Friday, July 5th, 1946.

Conferences with representatives of the San Francisco Convention Bureau and the Central Executive Committee were mentioned, with reference to: plans for the Scientific Section meetings in the Civic Center, hotel reservations for visiting members, entertainment features, such as the Dinner to the A.M.A. President and to the A.M.A. Delegates, and other matters.

11. **C.M.A. Advisory Planning Committee:**

Chairman Hunton recommended for the Committee that a complete inventory of all available medical facilities in California be compiled and widely publicized in order to acquaint the people of the State with the facilities open to them in case of need. It was recommended that Alameda County be used as a testing ground for such an inventory and that the results obtained there be used as a basis for determining whether or not a complete statewide inventory should be made. Approved by the Council.

The Committee further recommended that the C.M.A. take over the publication of the "Courier," official publication of the Woman's Auxiliary to the C.M.A., and make this a part of the Association's public relations campaign. Estimated cost of bi-monthly publication was set at $3,000 for the first year and $2,000 for succeeding years. Approved by the Council.

The Committee reported that it had devoted its December and January meetings to a study of California Physicians' Service requested by Doctor L. R. Chandler, Chairman of the C.M.A. Committee on Prepaid Medical and Hospital Care. The chairman stated that this study had been completed and asked instructions from the Council as to whether the report should be given to the Council or direct to the Chandler committee. In order to permit no question as to the Council's exercising any restraint on the Chandler committee, it was voted that the report should be given to that committee and not to the Council. (After presentation of this report to the Chandler committee, that committee voted to forward copies of the Advisory Planning Committee report to the Council.)

12. **Annual Session of C.M.A. in 1946:**

Chairman of the Committee on Scientific Work, Doctor George H. Kress, made a progress report concerning the plans that had been outlined for the 75th Annual Session of the California Medical Association to be held in Los Angeles at Hotel Biltmore, commencing Tuesday, May 7th, through Friday noon, May 10th.

It was stated that at the present time the Hotel Biltmore is the only large hotel that has facilities that can provide meeting places for the California Medical Association (with meeting rooms for the thirteen Scientific Sections, Council, House of Delegates, Woman's Auxiliary); also that owing to the week-end demands for use of the hotel facilities by transient guests, the Hotel Biltmore had stipulated that it could only make arrangements for the California Medical Association during the mid-week (for which reason the meeting necessarily could not begin before Tuesday, and must be closed before Saturday). Owing to the above limited facilities, and also because of the conditions under which members in civilian practice had been working, there would be no attempt this year to provide scientific exhibits.

Tentative report was made concerning the scientific programs.

Regarding guest speakers, President Gilman stated he would place in nomination for the President's guest speaker, Doctor James C. McCann of Worcester, Massachusetts, who would speak on some surgical problems in connection with anesthesia, and also would address the House of Delegates on prepayment medical service plans.

Discussion was had concerning nominations that had been presented for guest speakers to represent (1) the Medical Section and its affiliated specialties, and (2) the Surgical Section and its affiliated groups. After full discussion, it was decided to permit the Officers of the Sections on Medicine and Surgery to have authority to secure their respective guest speakers. (The guest speaker for the Medical Groups will be Doctor Allen T. Kenyon of the University of Chicago; for the Surgical Groups, Doctor George T. Pack of Cornell Medical College, New York.)

13. **Woman's Auxiliary:**

(a) Proposed amendments to the Constitution and By-Laws of the Woman's Auxiliary to the California Medical Association were presented and after consideration, motion was made and carried that the same be approved. (Proposed amendments appear in California and Western Medicine for February, on page 87.)

(b) On arrangements concerning "The Courier" (Woman's Auxiliary publication), see Item 11 in these minutes.

14. **"California and Western Medicine":**

Attention was called to the delayed appearance of California and Western Medicine in the mails due to printing plant difficulties. (Item discussed in more detail in February, 1946, California and Western Medicine, on page 67.) Under current man-power deficiencies in the printing trade, it was difficult to bring about an improvement.

15. **Legal Department:**

(a) Industrial Accident Commission.—Legal Counsel reported that a new petition, seeking an increase in the industrial accident fee schedule, had been filed with the members of the Industrial Accident Commission in December, 1945, and that a hearing on the petition had been requested but that to date there has been no action taken of any kind by the commission. It was also reported that the Assembly Interim Committee on Insurance, which is empowered amongst other things to investigate the adequacy of medical fees under the Industrial Accident Law, may hold a public hearing on the subject in the near future. If the Assembly Interim Committee does hold a public hearing, representatives of the Association will be present to submit to the committee a full statement of the facts involved, in an effort to secure the committee's coöperation in the Association's drive for a more equitable and adequate Industrial Accident fee schedule.

(b) Progress Report of the C.M.A. Cancer Commission.—Legal Counsel reported that at the request of the C.M.A. Cancer Commission, a California non-profit corporation had been formed, known as the American Cancer Society, California Division. This corporation will consist of a board of fifteen directors, nine of whom will be members of the Cancer Commission, the other six being representative members of the general public. The American Cancer Society, California Division, will act as a non-profit charitable organization devoted to public education in the field of cancer and to the use of all legitimate means to assist in the prevention and control of cancer. By virtue of the fact that a majority of its directors are members of the C.M.A. Cancer Commission, full control over its activities will at all times be vested in the C.M.A. (See also, Item 17.)

(c) Practice of Dentistry.—It was reported that an inquiry had been received for an opinion with respect to the legal right, if any, of dental surgeons to treat complications arising out of fractured jaws. A copy of legal counsel's opinion was submitted to each councilor.

(d) Solano County Medical Society.—A full report was made to the Council with respect to contract practice by certain physicians in Solano County.

(e) C.P.S. v. Garrison, Insurance Commissioner.—Legal Counsel reported that this case, which involves the question of whether C.P.S. is or is not subject to the insurance laws, is now pending in the California Supreme Court, that the case has been fully argued both orally and in writing, and has been submitted to the court for decision, and that a decision may be expected within the next two or three months.

16. **Permanente Hospital:**

A letter from the Solano County Medical Society in re: medical care procedures by members of the Permanente Hospital group, was submitted.

Discussion was had of the points involved, and it was agreed that a letter should be sent to the Solano County Medical Society in regard thereto. (Explanatory letters have been forwarded to component county medical societies.)

17. **C.M.A. Cancer Commission:**

Report was made by the Chairman of the Cancer Commission, Doctor Lyell C. Kinney of San Diego, who referred to his visits to the Cancer Clinics in the East, and the information there gathered. The importance of adequate professional control of Cancer Clinics was emphasized. Also, that the administration of this type of work should not be on a national, but on a state and local level. Therefore, it would be important to establish standards to aid local groups in carrying on their supervision.

It was stated, concerning moneys raised by the American Cancer Society, through appeal to the public, an estimated allocation of $800,000 would be made for California of which $500,000 would be used for local cancer clinics.

It was agreed that the subject should be given special consideration at the next meeting of the Council. (See also, Item 15 (b).)

18. **Executive Secretaries for County Medical Societies:**

Doctor A. E. Moore, President of the San Diego County Medical Society, addressed the Council and asked consideration of a plan whereby some of the smaller component county societies would be aided in securing executive secretaries through allocation of funds from the California Medical Association.

Full discussion followed and the Council voted that a special committee should be appointed to survey the entire situation and bring in a report to the Council. The Committee appointed consists of Lloyd Kindall, Chairman; E. Vincent Askey, and Walter S. Cherry.

19. **Time and Place of Next Meeting:**

On motion made and seconded, it was voted that the next meeting of the Council should be held in Los Angeles on Monday, May 6, 1946.

20. **Executive Session:**

The Council went into executive session, Councilor Cline acting as secretary. The following business was transacted:

(a) *A History of the California Medical Association.*—Reference was made to the desirability of compiling a history of the California Medical Association, now in its 75th year, the subject having been considered at the 328th and 329th Council meetings. (California and Western Medicine, October, 1945, Item 20(e), page 180; and December, 1945, Item 24, page 282.)

After discussion, on motion made and seconded, the following resolution was adopted:

Resolved, That the position of Honorary Historian of the California Medical Association is hereby created, said position to be entirely honorary and without compensation; and be it

Further Resolved, That the retiring Secretary-Editor, Doctor George H. Kress, be appointed as Honorary Historian, he to act in that capacity until such time as other action is taken.

(b) *Committee to Determine Editorial Policy.*—Since Doctor Kress, who has been editor of California and Western Medicine since March, 1927, will retire as Editor of the *Official Journal* at the close of this year's Annual Session, it was voted that the Council Chairman appoint a committee to submit to the Council a report on future editorial policy to California and Western Medicine. (Committee appointed: Councilors John W. Cline, E. Vincent Askey, and R. Stanley Kneeshaw.)

(c) *Proposed Amendment to Consitution.*—It was agreed to consider proposal of an amendment to the C.M.A. Constitution (Article V, Section 12), which would not make it mandatory that the persons occupying the positions of Association Secretary and of Editor of California and Western Medicine, must possess the degree of Doctor of Medicine.

(d) *Report of Publicity Counselor.*—The work of publicity counselor, Mr. Clem Whitaker, was discussed; a budget being submitted, and approval was given thereto.

(e) *Retirement of Doctor George H. Kress as Secretary-Editor.*—Doctor George H. Kress having reached retirement age, and the Council having considered the subject at the 328th meeting on August 21, 1945 (October California and Western Medicine, Item 20, page 108), and at the 329th meeting on October 21, 1945, discussion followed on what would be proper recognition of services rendered over many years by Dr. Kress.

After discussion, and on motion duly made, seconded, and carried, the following resolution was adopted:

Resolved, That the Council include in its annual report to the House of Delegates at the May, 1946, session, a recommendation that Dr. George H. Kress, presently the Secretary and Editor of the Association, be granted retirement status; and that in recognition of his many years of continuous and devoted service to the welfare of the Association, Doctor Kress be granted a pension for life, commencing at the end of the 1946 annual session, payable at the rate of $315.00 per month; provided, only, that in any month or months during which Dr. Kress accepts or undertakes any salaried position or positions carrying the aggregate compensation in excess of $15.00 per month, then for such month or months, Dr. Kress shall not receive the monthly pension aforesaid.

(e) *On Retirement Plans of Employees.*—After discussion, it was agreed that the Council submit to the House of Delegates a request that a definite plan be established concerning conditions under which employees of the California Medical Association would be retired in the future. (Committee appointed: Councilors John W. Cline, E. Earl Moody, and Frank A. MacDonald.)

21. **Adjournment:**

After recess, there being no further business, it was voted to adjourn.

Philip K. Gilman, M.D., *Council Chairman,*
George H. Kress, M.D., *Council Secretary.*
GHK/s

MEMBERS' SPECIAL MEETING OF "TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION"

Minutes of the Nineteenth (19th) Meeting of Members of "Trustees of the California Medical Association"

Pursuant to call of the president and notice by the secretary duly and regularly given in accordance with the By-laws, a special meeting of the members of the "Trustees of the California Medical Association," a California corporation, was held at the Hotel Biltmore in Los Angeles, on Friday, February 1, 1946.

1. **Roll Call:**

Members Present: Philip K. Gilman, E. Vincent Askey, Sam J. McClendon, Edwin L. Bruck, Sidney J. Shipman, E. Earl Moody, Dewey R. Powell, Edward B. Dewey, Walter S. Cherry, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary.

Members Absent: Herbert A. Johnston.

A quorum present and acting.

2. **Authorization to Purchase U. S. Bonds:**

On motion duly made, seconded, and carried, the following resolution was adopted:

Resolved, That current funds be used to purchase $25,000 par value U. S. Treasury bonds bearing interest at the rate of two and one-half per cent per annum.

3. **Adjournment:**

There being no other business, on motion duly made and seconded, it was voted to adjourn.

PHILIP K. GILMAN, M.D., *President*
GEORGE H. KRESS, M.D., *Secretary*

GHK/s

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the One Hundred Ninety-seventh (197th) Meeting of the Executive Committee of the California Medical Association

The meeting was called to order at 6:00 P.M., on Friday, March 1, 1946, at The Family Club in San Francisco.

1. **Roll Call:**

Members Present: Doctors John W. Cline, Chairman; Philip K. Gilman, Sam J. McClendon, and George H. Kress, Secretary.

Member Absent: Doctor E. Vincent Askey.

Present by Invitation: Doctor Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; Doctor Edwin L. Bruck, member Auditing Committee; Mr. John Hunton, Executive Secretary; Mr. Howard Hassard, Associate Legal Counsel, and Mr. W. M. Bowman, Executive Director, California Physicians' Service.

2. **C.M.A. Representatives to Appear Before Senate Committee on Prepayment Medical Service Plans:**

(a) Discussion was had concerning representatives of the California Medical Association who might be in position to appear before the special Senate Committee that would hold hearings on the Wagner-Murray-Dingell Bill (S. 1606), scheduled to begin between March 14th and March 18th.

It was stated that it had been suggested that Ex-President Lowell S. Goin of Los Angeles, who is President of the Board of Trustees of California Physicians' Service would be a proper representative in case he could make arrangements to go. It was felt that Doctor Goin's knowledge would make him a proper representative of both the California Medical Association and California Physicians' Service.

(b) Attention of the Committee was called to the suggestion that had been made that the National Physicians' Committee might also send to be present at the hearings, Doctors Lloyd Kindall of Oakland, John W. Green of Vallejo, and Jay J. Crane of Los Angeles. The opinion was expressed that these colleagues would be in position to give valuable service through informing California Congressmen concerning the prepayment medical and hospital service plans that are in operation in California.

It was further agreed that Doctor Cline, Chairman of the Executive Committee, should hold a special conference with Doctors Kindall, Green and Crane relative to the general plans.

Agreed further, that Doctor Dwight H. Murray, Chairman of the C.M.A. Committee on Public Policy and Legislation, should keep in touch with the procedures to be inaugurated.

3. **Membership: Retired; Associate:**

(a) Mr. Hunton presented applications for Retired Membership, these applications having been presented in proper form, as follows:

William H. C. Hatteroth, Alameda County
Frank E. Sawyer, Alameda County
Dow Harvey Ransom, Fresno County
Clark D. Baker, Los Angeles County
Charles L. Bennett, Los Angeles County
F. H. Frandt, Los Angeles County
Charles Burnside, Los Angeles County
Thomas Sheridan Carey, Los Angeles County
William T. Clarke, Los Angeles County
Peter T. Conlan, Los Angeles County
Cassius C. Cottle, Los Angeles County
E. H. Crane, Los Angeles County
Henry W. Edwards, Los Angeles County
Frank W. Hanford, Los Angeles County
John Peachy Jones, Los Angeles County
Ralph L. Kirsch, Los Angeles County
George A. Laubersheimer, Los Angeles County
Caroline McQuisten Leete, Los Angeles County
H. Cameron May, Los Angeles County
Anna E. Rude, Los Angeles County
Charles Stein, Los Angeles County
Charles W. Stewart, Los Angeles County
B. C. Tarnutzer, Los Angeles County
Silas A. Lewis, Los Angeles County
Harry W. Smiley, Riverside County
Harry H. Beauchamp, Sacramento County
George N. Bramhall, Sacramento County
George A. Spencer, Sacramento County
Alfred E. Banks, San Diego County
James D. Bobbitt, San Diego County
Nicholas Molitor, San Diego County
Frank C. Russell, San Diego County
Frank B. Schroeder, San Diego County
John A. Bacher, San Francisco County
August J. Lartigau, San Francisco County
T. Howard Plank, San Francisco County
Wallace Bruce Smith, San Francisco County
Harold O. von der Lieth, San Francisco County

On motion made and seconded, Retired Membership was granted to the above members.

(b) Concerning applications for Associate Membership, it was voted that it be the policy that Associate Membership be granted to applicants who have been duly certified as not being in private practice.

Applications for Associate Membership having been received from the county societies in proper form, with certification that the members are not in private practice, Associate Membership was granted to the following:

J. Hallam Cope, Alameda County
Floyd D. Lewis, Alameda County
James A. McKenney, Alameda County
M. H. Merrill, Alameda County
Jewel M. Sanders, Alameda County
W. W. Stadel, Alameda County
Herbert R. Stolz, Alameda County
George A. Walton, Alameda County
Genevieve Gaard, San Mateo County
Erma Macomber, San Mateo County
Ira Church, Santa Barbara County

C. T. Roome, Santa Barbara County
L. C. N. Wayland, Santa Barbara County

4. United Public Health League:

Mr. Hunton was requested by Chairman Cline to inform persons interested concerning steps that had been taken concerning legislative matters. (Letters to Doctor Molony and Mr. Tom Hendricks.)

5. Report on Meeting of A.M.A. House of Delegates:

Doctor Dwight H. Murray was asked to comment informally concerning some of the actions taken at the meeting of the House of Delegates of the American Medical Association held on December 3-6, 1945.

Those present felt that the actions taken by the C.M.A. Delegates were in harmony with the best interests of the Association.

6. Medical Plan on Prepayment Basis for State of New Mexico:

Discussion was had concerning tentative plans to institute a medical service organization in New Mexico. It was stated that request had been made of the constituted authorities of the American Medical Association to subsidize this endeavor.

After discussion, it was agreed that the desirability of adding one more nearby state unit to the group of state prepayment organizations operating on the Pacific Coast was most important; and in the event money was not forthcoming from the American Medical Association, it was felt the California Medical Association should stand ready to advance the money to the New Mexico colleagues who have the plans in hand.

It was agreed that Doctor Murray should write to one or two friends, acquainting them with this decision.

7. Meeting of the American Medical Association in 1946 in San Francisco:

Informal report was made by Doctor John W. Cline, Chairman of the Committee on Arrangements, concerning the plans for the 1946 meeting of the American Medical Association to be held in San Francisco July 1-5, 1946.

Doctor Cline outlined the tentative plans concerning entertainment and other measures that had been gotten under way.

8. California Sickness Indemnity Bill (S.40):

Mr. Hassard commented upon the difficulties that had arisen in connection with the so-called Shelley Bill (S.40), through which sickness disability stipends would be given to Californians who were unemployed because of illness. Deficiencies which had crept into the measure were mentioned. It was agreed that further report should be made to the Council.

9. Adjournment:

There being no further business, the meeting adjourned.

JOHN W. CLINE, M.D., *Chairman*
GEORGE H. KRESS, M.D., *Secretary*

John Milton (1608-1674).—When the eyesight of Milton began to fail at thirty-six, the happy poet of earlier years was transformed into the savage political pamphleteer. By the time he was forty-four, totally blind, and reconciled to his fate, he turned again to his literary efforts. The constant help he needed was given him by his daughters and sometimes by young men, glad of his society, who acted as scribes and readers. He died at sixty-six when "gout struck in."—Warner's *Calendar of Medical History.*

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (49)

Alameda County (2)

Hatoff, Alexander, *Oakland*
Lowell, Max, *Oakland*

Los Angeles County (34)

Aaron, Ruth, *Beverly Hills*
Birnberg, Tobias L., *Beverly Hills*
Collins, Mary Ellen, *Santa Monica*
Cook, Ernest Dale, *Azusa*
Elek, Stephen R., *Los Angeles*
Fraser, Robert C., *Los Angeles*
Griffin, Richard Anthony, *North Hollywood*
Gutman, Ernest, *Los Angeles*
Harwood, David M., *North Hollywood*
Katz, Samuel D. H., *Los Angeles*
Kottke, Elmer E., *Los Angeles*
Kraft, George L., *Burbank*
Lapid, Gilbert G., *Long Beach*
La Scola, Raymond L., *Santa Monica*
Lauer, Marvin S., *Compton*
Lilly, Lewie John, *Huntington Park*
Lindegren, Lillian W., *Bellflower*
Luppi, Alfred Philip, *Los Angeles*
McCandliss, Charles H., *Los Angeles*
Mizener, Mark, *South Gate*
Nelson, E. A., *Los Angeles*
Nelson, James H., *Los Angeles*
Olson, William Adolph, *Burbank*
Perrin, John Hezekiah, *Huntington Park*
Polson, Adam Borden, *Los Angeles*
Schoeps, Martin, *Los Angeles*
Shevick, Irving M., *Studio City*
Spivey, William Lee, *Beverly Hills*
Stuppy, Lawrence J., *Los Angeles*
Townsend, Guy Walter, *Los Angeles*
Treusch, Jerome V., *Beverly Hills*
Tupper, Walter Richard, *Glendale*
Walker, Ethel M., *Glendale*
Wenkle, William C., *Olive View*

San Diego County (5)

Gaede, Eva Marie, *La Jolla*
Peterson, Elmer, *San Diego*
Stadden, John C., *Vista*
Woods, Ward W., *San Diego*
Wyborney, V. J., *San Diego*

San Francisco County (7)

Boyd, Robert T., *San Francisco*
Hrenoff, Arseny K., *San Francisco*
Klabunde, Paul W., *San Francisco*
McGettigan, Daniel Louis, *San Francisco*
Nahman, Morton Sidney, *San Francisco*
Sawyer, Harry William, Jr., *San Francisco*
Wolter, Nathan, *San Francisco*

San Luis Obispo County (1)

French, Edison A., *San Luis Obispo*

Transfers

Alden, Ward C., from *Los Angeles County* to *San Bernardino County*
Arminino, Louis P., from *San Francisco County* to *San Joaquin County*

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† For roster of officers of component county medical societies, see page 4 in front advertising section.

Blasdel, Edward K., from *Tulare County* to *Alameda County*
Brown, Lawrence E., from *Riverside County* to *Alameda County*
Clemens, Harry H., from *Yuba-Sutter-Colusa County* to *Los Angeles County*
Dail, Clarence W., from *San Bernardino County* to *Los Angeles County*
Falk, Lane, from *Humboldt County* to *Stanislaus County*
Falk, E. V., from *Stanislaus County* to *Humboldt County*
Fletcher, Harold A., from *San Francisco County* to *Marin County*
Geen, Robert S., from *San Benito County* to *Alameda County*
Gill, Gerald G., from *San Francisco County* to *Alameda County*
Hall, Samuel P., from *San Francisco County* to *Alameda County*
Ing, Henry, from *San Diego County* to *San Joaquin County*
Meister, Lester, from *San Bernardino County* to *Los Angeles County*
Schimmenti, John M., from *Alameda County* to *San Francisco County*
Schock, Robert H., from *Monterey County* to *Alameda County*
Watson, George A., from *Solano County* to *San Francisco County*

Retired Members (37)

Bacher, John Adolph, *San Francisco County*
Baker, Clark Dyer, *Los Angeles County*
Beauchamp, Harry H., *Sacramento County*
Bennett, Charles L., *Los Angeles County*
Bobbitt, James Douglas, *San Diego County*
Bramhall, Robert N., *Sacramento, County*
Brandt, Franz Henry, *Los Angeles County*
Burnside, Charles, *Los Angeles County*
Carey, Thomas Sheridan, *Los Angeles County*
Clarke, William Thomas, *Los Angeles County*
Conlan, Peter T., *Los Angeles County*
Cottle, Cassius Clay, *Los Angeles County*
Crane, Edward Harrison, *Los Angeles County*
Edwards, Henry W., *Los Angeles County*
Hanford, Frank Wood, *Los Angeles County*
Hatteroth, William H. C., *Alameda County*
Jones, John Peachy, *Los Angeles County*
Kirsch, Ralph Louis, *Los Angeles County*
Lartigan, August Jerome, *San Francisco County*
Laubersheimer, George Ashby, *Los Angeles County*
Leete, Caroline McQuiston, *Los Angeles County*
Lewis, Silas A., *Los Angeles County*
May, H. Cameron, *Los Angeles County*
Molitor, Nicholas, *San Diego County*
Plank, T. Howard, *San Francisco County*
Ransom, Dow Harvey, *Fresno County*
Rude, Anna E., *Los Angeles County*
Russell, Frank Christopher, *San Diego County*
Sawyer, Frank Everett, *Alameda County*
Schroeder, Frank Bernard, *San Diego County*
Smiley, Harry Wilbur, *Riverside County*
Smith, Wallace Bruce, *San Francisco County*
Spencer, George A., *Sacramento County*
Stein, Charles, *Los Angeles County*
Stewart, Charles Wesley, *Los Angeles County*
Tarnutzer, Benjamin C., *Los Angeles County*
von der Lieth, Harold Otto, *San Francisco County*

Associate Members (13)

Church, Ira, *Santa Barbara County*
Cope, J. Hallam, *Alameda County*
Gaard, Genevieve, *San Mateo County*
Lewis, Floyd D., *Alameda County*
Macomber, Erma, *San Mateo County*
McKenney, James A., *Alameda County*
Merrill, M. H., *Alameda County*
Roome, C. T., *Santa Barbara County*
Sanders, Jewell M., *Alameda County*
Stadel, W. W., *Alameda County*
Stolz, Herbert R., *Alameda County*
Walton, George A., *Alameda County*
Wayland, L. C. N., *Santa Marbara County*

Resignations (2)

Galbraith, Elizabeth Hosmer, *San Francisco County*
Olson, George M., *Los Angeles County*

In Memoriam

Bullitt, James Bell. Died at San Jose, February 24, 1946, age 82. Graduate of the University of Louisville School of Medcine, Kentucky, 1889. Licensed in California in 1921. Doctor Bullitt was a Retired Member of the Santa Clara County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✚

Frey, William C. Died at San Francisco, February 23, 1946, age 53. Graduate of the University of California Medical School, Berkeley-San Francisco, 1917. Licensed in California in 1917. Doctor Frey was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✚

Siebe, Elizabeth B. Died at San Francisco, February 18, 1946, age 75. Graduate of the College of Physicians and Surgeons of San Francisco, 1904. Licensed in California in 1904. Doctor Siebe was a Retired Member of the San Francisco County Medical Society, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✚

Walter, Frederick Jerome. Died at La Jolla, February 14, 1946, age 72. Graduate of the Chicago Homeopathic Medical College, Illinois, 1897. Licensed in California in 1920. Doctor Walter was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Contact Lenses

(An Opinion of State Attorney General)

"Unlicensed persons are forbidden under the State business and professional code from fitting so-called 'contact' lenses, worn under the eyelid in lieu of spectacles, State Attorney General Robert W. Kenny ruled yesterday. . . . The ruling, prepared by Deputy Attorney General J. Albert Hutchinson, was in reply to an inquiry from the State board of medical examiners, who pointed out some of this work was being done by unlicensed workers. . . . 'Contact lenses may be prepared and fitted to the eye by optometrists if this can be accomplished without the use of drugs or other medical preparations or surgery; dispensing opticians and unlicensed persons may not perform these services,' the digest of the opinion said." (San Francisco *Examiner.*)

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

Report of Fee Complaint Committee of Los Angeles County Medical Association

The Bulletin of the Los Angeles County Medical Association in its issue of February 7, 1946, printed the following report of the Los Angeles Fee Complaint Committee, submitted to the Council on January 7:

Gentlemen: The end of the year 1945 makes a report from the Fee Complaint Committee advisable, and gives its chairman an opportunity to philosophize and comment on what he has learned as a member of the Committee.

During the past year the Committee has completed the disposition of more than fifty-two written complaints as to fees charged by members of the Association. Of these, one is presented to the Council for further action, and one is awaiting further information, otherwise all are completed. In addition a considerable number of potential cases have been settled or compromised without coming to official notice. On the whole, the decisions of the Committee have been accepted with approbation or acquiescence by both complainant and complainee.

In the light of experience on the Committee over the past three years a pattern as to the complaints is beginning to appear, and a rough mathematical ratio may be approximated.

In about one-half of the cases patients, or their families, are entirely at fault, either because of being disgruntled, or failing to comprehend, through ignorance or illness.

In about one-fourth of the cases the doctors, while blameless to a high degree, have failed somehow to give their patients a clear and complete understanding as to fees and time of payment. This may be due in part to the lack of efficient help in the office, or to stress of work during the strenuous war years.

The remaining one-fourth is about equally divided into these three categories:

1. Mostly of recent membership in the Association, some speaking broken English, most with foreign education. They either cannot or will not learn the ways of the American physician. They become arrogant without cause, charge specialist fees, and bring undue pressure on patients to pay, regardless of ability to pay exaggerated fees. They seem to be worshipers of the "Golden Calf" rather than followers of the "Golden Rule."

2. Otherwise decent physicians, overworked and harassed and exasperated by nagging, unreasonable patients. These doctors, in a moment of pique, stung by a multitude of barbs of unreasoning calls on their time and thought, will tell their secretaries, "Double that bill, maybe that will make them realize that other patients need attention." The doctor or his secretary then forgets his immediate pique, and in due course of time the doubled account is given to a collection agency which then brings pressure for payment, often with threat of legal action. This variation of the usual or established fee schedule is uncollectible by legal means, and if attempted is apt to bring on the doctor a stinging rebuke from the court. Most physicians, when their attention is called to this point are thoroughly ashamed of their action, natural thought it be.

3. This type comprises the least in number, but the most dangerous. It is composed of physicians regrettably in the Association. They are such as make unconscionable charges, exaggerate the value of their services, bring great pressure on patients or relatives to pay, flatter their patients early, and then coldly demand their "pound of flesh." They are apt to be repeaters in having complaints brought against them, apparently not learning from experience or advice. They bring the Association into bad repute, they make it difficult for other members to secure coöperation with the public, and by implication they put the Association on the defensive with the public. I consider these to be the most dangerous of all the types enumerated.

During the past difficult year the Committee has given of its time, thought, and experience freely and willingly, with the utmost in coöperation between its members, and the chairman hereby acknowledges his indebtedness and thanks to his fellow members for their effort and coöperation. Also the Committee takes this occasion to congratulate the Association on the efficiency and understanding exhibited by the headquarters clerical staff, especially by Miss Thomas, on whom the burden has fallen to the greatest degree, and to Mr. Cochems, for his sound common sense and his timely advice.

Finally, the Committee has worked hard and deserves a rest.

Respectfully submitted to the Council.

The Fee Complaint Committee,
(Signed) George P. Laton, M.D.,
Chairman. (Jan. 4, 1946.)

Group Accident-Sickness Insurance Program of the Los Angeles County Medical Association

The number of applications flowing in with every mail indicate that enrollment qualification for the Association's Group Accident and Sickness policy shortly will be complete.

While obviously good news for those members who have applied, the close of the qualification period will mean a lost opportunity for those present members who have not made application, since (except for new members and returning military personnel) insurance on the present basis will not be obtainable after enrollment period expires.

Following this original enrollment period, applicants who are present active members will be required to demonstrate full insurability from a physical standpoint. This will be particularly unfortunate for the older members, since experience on the part of insurance companies indicates that applicants over 50 years of age, in large percentage, fail to qualify for sickness insurance in view of medical histories considered unfavorable for that type of protection.

As to cost: Members who have checked the rates charged and policy conditions, under the Association's program, with rates charged and conditions, under individual policies, have, understandably, asked, "How can this be?" since the normal relationship between quality and price does not exist in this insurance. Amount of indemnities and broadness of protection are unmatchable even at far greater cost.

Only the actual wholesale nature of group insurance makes possible the combination of complete deviation not only from normal costs, but also normal underwriting requirements and policy restrictions. From the insurance company's standpoint, the purchases of the membership represent a single sale to the Association; the collective premiums being paid from its Group Insurance account in a single sum twice a year. Hence, commission and collection costs are fractional compared to individual sales and the employment of the very brief and nonselective enrollment-application eliminates underwriting costs, inspection report and medical examination costs.

* * *

The San Diego County Medical Society closed its enrollment period with 82 per cent of its membership insured and the Southern California State Dental Association with 78 per cent of its membership. It is to be hoped that members of this Association who desire to protect that important asset, earning ability, will not, through oversight, neglect to apply during the enrollment period. This is the only time that the company is obligated to accept all applications from members in active practice and not having attained age 65.—*The Bulletin.*

* * *

Los Angeles Group Disability Insurance Plan Sets a Record

Enthusiastic participation by the membership of the Los Angeles County Medical Association has resulted in a new national record being established for a professional organization of this size. As of February 15, the end of the final extension of the qualification period, more than 79 per cent of the 3,000 active members were insured under the Association Group Disability Policy.

Even though the qualification period is closed, experience with other associations indicates that a continually larger percentage of members will participate by virtue of the very obvious benefits of the Group protection. Not only is the premium saving a substantial dividend on Association dues, but the terms and conditions of the policy far exceed those obtainable through individual purchase. Present members under the age of 65 may insure under the group at any time by submitting evidence of insurability satisfactory to the underwriting company. New members, and those returning from military service may obtain the benefits of this unusual protection without evidence of insurability providing they apply within sixty days of establishment of practice in the county.

Insurance has been in force since January 15 on all members who enrolled prior to that date. On all applying subsequently, insurance is in force on the date applications are received by the Nettleship Company, which organization is administering the program for the Association. Certificates of Insurance under the Group Policy will soon be in the hands of all who have enrolled.—*The Bulletin*, March 7, 1946.

"Grading" of Doctors in Alameda County

Oakland physicians and surgeons may soon find themselves classified as to ability for surgery or medical practice in hospitals throughout the Oakland area.

The plan is already in action at Oakland's Merritt hospital where two separate three-man boards have been set up to survey doctors applying for the use of Merritt hospital facilities.

Aim of the program, according to hospital directors, is to elevate hospital standards and improve medicine and surgery in Alameda county.

A three-man surgery committee at the hospital designate doctors as senior surgeons, surgeons or junior surgeons depending upon replies to a questionnaire and examination by the committee. By a similar manner, another three-man committee names doctors as internists or general practitioners at the hospital.

Protests to the plan brought the following statement from Rollen Waterson, executive secretary of the Alameda County Medical Association:

"The Alameda County Medical Association definitely approves any efforts on the part of any hospital to raise standards and we will coöperate."

He admitted that verbal protests have been made to the plan by some doctors on the grounds that they have not or may not be correctly classified by the hospital boards.

"While the medical association has received no formal protests, the verbal complaints have caused us to name a committee to investigate all methods employed by hospitals here in classifying doctors," Waterson said.

* * *

Meanwhile, 150 Alameda county physicians met Tuesday night at the Ethel Moore Memorial building in Oakland and organized a General Practitioners Association.

Dr. Stanley R. Truman, chairman of the new group, emphasized that its organization was not the outgrowth of any complaints against the new system established at Merritt hospital.

"It is our intention to give voice to the general practitioners and we hope to become a section of the Alameda County Medical Association eventually," he said.

He pointed out that the American Medical Association created a section on general practice at its annual meeting in Chicago last December, and Oakland doctors have patterned their association in the same fashion.—Oakland *Post-Enquirer,* February 21.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

University of California Medical School in San Francisco Receives an Additional $4.000,000 for Expansion of Its Medical Center

Examiner Bureau, Sacramento, March 6.—In a ceremony attended by many members of the staff of the University of California's medical center, Governor Warren signed today a bill appropriating $4,000.000 for reconstruction and expansion of the San Francisco institution.*

In addition to today's appropriation, hailed by leaders of the medical profession as paving the way for "one of the great medical schools of the world," the administration's $154 000.000 postwar construction program includes $5,080,000 for other facilities, and an additional $2,000,000 appropriation in 1943 also is available. This brings the total program to $11,080,000.

* * *

The $4,000 000 measure will make possible replacement of three buildings erected more than fifty years ago and designated as fire and earthquake hazards.

They house part of college of dentistry, pharmacy, library and valuable equipment and records.

In addition, $4,670,000 will be available for a teaching hospital, $2,275,000 for a medical science unit and $135,000 for dental clinic expansion.—San Francisco *Examiner,* March 7.

Governor Warren Signs Bill to Expand U. C. Medical Center in San Francisco

Governor Warren yesterday signed a bill appropriating $4,000,000 for the expansion of the University of California's medical center on Parnassus Avenue.

The Governor expressed the hope that the day will come when the State University Medical School will become "one of the great medical centers of the world."

The bill, introduced by Assemblymen Gardiner Johnson, Berkeley, and Thomas A. Maloney, San Francisco, will provide funds for the replacement of three buildings more than 50 years old. Buildings will be erected in their place to house the medical school, college of dentistry, college of pharmacy, and the library.

The additional space to be provided will permit moving to San Francisco from the Berkeley campus the departments of anatomy, physiology, and biochemistry. A teaching hospital will be completed. (See March CALIFORNIA AND WESTERN MEDICINE, p. 142.)

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* For Address of Governor Earl Warren, see p. 238.

The bill was signed in the presence of university officials. These included Dr. Francis F. Smyth, dean of the medical school; Dr. Troy C. Daniels, dean of the college of pharmacy; Dr. Willard C. Fleming, dean of the college of dentistry; James H. Corley, controller of the university; F. S. Durie, hospital superintendent, and others.

The Governor said he was particularly interested in the medical school aiding the general development of public health. He was assured by the doctors present this would take place.

Dr. Hamilton H. Anderson, however, said that while there are centers to treat tropical diseases in New York and New Orleans, there are none in California to take care of the "Pacific basin." Warren said he believed establishment of such a center was desirable to care for the many veterans returning with malaria and other diseases. —San Francisco *Chronicle,* March 7.

(Note. Governor Earl Warren also signed the bill for a $7,500,000 appropriation to establish a new medical school—probably a department of the "University of California at Los Angeles," on February 20, 1946.)

Medical School Honor

Dr. John R. Mitchell Receives Cane, Traditional Prize of Profession

A gold-headed cane has become the most prized possession of Dr. John R. Mitchell, 45 Lincoln Way, a recent graduate of the University of California Medical School.

It was presented to the 31-year-old physician by Dr. William J. Kerr, head of the school's medical department, after Dr. Mitchell had been voted by faculty and students as the member of his class having "outstanding qualities of a true physician."

For the last eight years presentation of a gold-headed cane has been a feature of graduation ceremonies of the medical school. The cane always is inscribed with the name of the winner and the sign of Hippocrates, and carries with it a scroll stating why the recipient was chosen for the honor.

A native of Manchester, Mo., Dr. Mitchell is married and the father of a two-year-old son. — San Francisco *Chronicle,* February 23.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Los Angeles Medical Veterans Group Organized

A general meeting of Physician Veterans was held in the lounge of the Los Angeles County Medical Association on January 4. At the request of a number of interested physicians invitations were sent by the Secretary of the County Medical Association to all known physicians in the five Southern California counties who have returned from active duty with the Armed Forces. Announcements were also sent to all military and civilian hospitals in the area.

Dr. Louis J. Regan, President of the County Medical Association, opened the meeting and offered the assistance and facilities of the Association in forming an organization of Veteran Physicians. He later expressed the opinion that the group would be more influential in matters of public interest if it were independent, and not a part of present medical organizations.

The group decided to form a permanent organization of Medical Veterans. Nominations were received from the floor and the following were elected temporary officers: President, William Leake, M.D.; Vice-President, Wells C. Cook, M.D.; Secretary, Frederick A. Bennetts, M.D.; Treasurer, William Delphey, M.D.

The following were named members of the Executive Committee: Doctors Clarence J. Berne, Lewis T. Bullock, Paul D. Foster, Ralph E. Netzley, J. Norman O'Neill, Edward C. Pallette, Robert Stern, and Warren A. Wilson.

The Executive Committee was directed to prepare a Constitution and By-Laws to be considered at the next meeting. It is proposed that the organization be national in scope with units in all states and counties.

The organization has the immediate purpose of assisting physicians returning from the armed services in reestablishing their practice in order that they may make a contribution to the health of their communities and earn a living for their families. It is felt that the group has the universal backing of all doctors in this purpose. A meeting of the Executive Committee has been held and committees appointed to attempt to solve the problems of office space, purchase of surplus medical property, delay in obtaining narcotic licenses, and ineligibility of physicians on terminal leave to the educational and loan provisions of the G.I. Bill of Rights.

A unified approach to the governmental agencies responsible for providing assistance which is theoretically available to veterans may eliminate some of the present inefficiency. A committee has also been appointed to develop a liaison with other veterans' organizations. The feasibility of association of the Medical Veterans' group with one of the regular veterans' organizations is being considered.

The organization has the eventual purpose of utilizing the experience in governmental medicine of many capable physicians for the improvement of the health of the country and the medical care provided for the Army and for veterans. Apparently many false statements have been made concerning the conclusions of capable physicians, after extensive experience in governmental medicine, concerning the value of governmental influence in providing medical care for the individual.

The crystalization and expression of the opinion of all veteran physicians concerning the effect of further governmental influence over the private practice of medicine should be of great value to the country in deciding upon proposed changes in the method of providing the most efficient medical care for the average citizen. The organization proposes to determine and express the opinion of Veteran Physicians concerning socialized or governmental medicine.

If national organization can be completed in time the group may be of value to private physicians still in the armed services. Medical officers are unable to express their opinions. In the past war no group has considered the question of the waste of medical talent by the regular services. No group has investigated the question of whether promotions in the Medical Corps were correlated with training, experience and ability. Volunteer physicians in the armed services have had no voice. In case of a future war, the existence of a civilian organization with experience and interest in medical service in the Armed Forces should be of value in providing an efficiently organized Medical Corps.

The President was requested to express the appreciation of the group for the consideration shown by the County and State Medical Associations in the matter of dues for 1946. He was requested to express the appreciation of the group to the County Medical Association for its assistance in holding the organization meeting.

On Organization Plans for Medical Veterans*

(COPY)

MEDICAL VETERANS' ASSOCIATION OF
LOS ANGELES COUNTY
1921 Wilshire Boulevard
Los Angeles, Calif.

March 23, 1946.

Dr. George H. Kress. Editor,
CALIFORNIA AND WESTERN MEDICINE, *Addressed.*

Dear Mr. Editor:

Enclosed is a letter, relative to the "Medical Veterans' Association of Los Angeles County." This Association has been organized and is very desirous of publicizing the type of organization, its objectives and aims to the medical veterans generally, so that additional organizations may be formed throughout the country, in the hope that this organization may play a significant rôle in expressing opinions relative to proposed legislation affecting the practice of medicine.

We believe printing of this letter in CALIFORNIA AND WESTERN MEDICINE will greatly facilitate the forming of this organization, which we believe will directly assist organized medicine in its campaign to maintain the high standards of practice and avert political control of medicine.

We would greatly appreciate your coöperation in this matter and the publication of the inclosed article in your Journal, in an early issue.

Yours very truly,

(Signed) F. A. BENNETTS, M.D., *Secretary.*

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WARREN A. WILSON, M.D.

* * *

MEDICAL VETERANS' ASSOCIATION OF LOS ANGELES COUNTY

Why Medical Veterans Should Organize

Physicians returning from military service will face many problems in reëstablishing their practice which may advantageously be approached through mutual association. The combined experiences of these men in the past war will be of great value to this country in solving the problem of medical care for the public and for the soldiers in case of a future war. The excellent performance of the Medical Corps, and the unselfish devotion of the medical officers to the welfare of the country in the war, is universally recognized by the public. The opinion of these men concerning methods of providing the best medical care for the public will receive respectful attention by the public. The physician veteran will continue to have particular interest in addition to those of all other veterans. An organization of medical veterans will have a useful function in the problems facing the medical profession, the veterans themselves and the public.

After a preliminary meeting of a few interested men, a general meeting of all medical veterans in Southern California was called in Los Angeles on January 4, 1946. A decision was made to form a permanent medical veterans organization. The following officers were elected: President, William H. Leake; Vice-President, Wells C. Cook; Secretary, Frederick A. Bennetts; Treasurer, William E. Delphey. A committee was appointed to draft a constitution and by-laws. The name Medical Veterans' Association was adopted and subsequently the constitution and by-laws approved by the membership. It is proposed that this eventually be a nation-wide organization. It is hoped that similar groups will be formed in other areas to help solve the immediate problems of returning physicians and that these eventually be combined. The Secretary will be pleased to provide copies of the constitution and by-laws of the California group to any veterans group interested in the project.

The chief aims of the organization are considered to be the following:

1. To assist the returning physician in every possible way in reëstablishing his practice.

2. To assure that the highest standards of medical care be provided for the treatment of all veterans with service-connected disabilities.

3. To crystallize the experience of former medical officers in governmental medicine, to determine their conclusions concerning the value of governmental influence over the practice of medicine, and to publicize these conclusions.

4. To advise and assist in the improvement of the organization of the medical services of the United States Armed Forces for future emergencies.

Various committees have been very busy in helping to solve the problems of returning physicians. The housing committee has had numerous meetings with the medical building managers, has developed certain principles in the allotment of available space to protect the returning doctors, and has had representatives of the building managers address the group. The narcotic license committee has helped to reduce the time required to obtain a narcotic license with which to restart practice. The surplus property committee has had numerous meetings with representatives of the Reconstruction Finance Corporation and the War Assets Corporation in an effort to make surplus medical property available to returning doctors. A representative of War Assets Corporation is addressing each meeting of the group concerning their progress with this problem. The committee recently testified before a Senate investigating committee composed of senators.

They outlined the complete confusion existing at present and were promised a solution of the problem by the senators. A committee at present is working on an exception in the law which excludes most physicians from the tax exemption said to be available to veterans.

There will be numerous problems arising concerning medical care for veterans. The group of medical veterans appear to be well-qualified to advise the government concerning these problems.

Many unsupported and apparently incorrect statements have been made concerning the attitude of doctors in the Armed Forces concerning the value of governmental supervision of the practice of medicine. The real conclusions of these men who have had extensive experience with governmental supervision, and whose sincerity cannot be questioned, is a matter of great public importance. This group proposes to determine and express the ideas of these men on the subject.

In the past war many difficulties faced by medical officers could have been avoided if there had been a civilian group experienced and willing to call the facts to public attention. In case of a future war a group of men who have had experience with the problems should be of great value to the doctors who under the facts of military discipline cannot speak for themselves.

Such a new organization obviously faces two dangers. The hardships experienced in the Army and on return to civilian life could result in an excessive attitude of selfish aggrandizement for the veteran. This problem has been avoided by the Los Angeles group, which has received the wholehearted support of the entire profession in its reasonable program to assist the veteran in returning to his practice. After the immediate problems are solved there may be a loss of interest. There appear to be numerous problems which will give the organization a permanently useful function to its members, the profession and to the public.

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* Note. For notice of a meeting in Los Angeles, see in "Pre-Convention Bulletin," on page 196.

The organization can be most useful with no connection with the County Medical Association or the American Medical Association and the constitution makes it entirely independent. The Los Angeles County Medical Association has offered its entire facilities and has been most helpful in getting the organization started. It is anticipated that groups in other areas will receive the same degree of coöperation.

A liaison has been established with the other veteran organizations. Extensive coöperation with them is planned, particularly in considering medical problems. Some type of affiliation may be considered in the future. Many members of the group are also members of a regular veterans organization.

After careful consideration membership was made available to medical veterans of all United States armed conflicts. Veterans of World War II will undoubtedly be in the great majority. Membership is also open to veteran dental and nursing corps officers of the Army, Navy, Coast Guard and Public Health Service.

It is felt that the organization of similar groups in other communities will be of benefit to the returning doctors, the medical profession and the public.

* * *

The Bulletin of the Los Angeles County Medical Association for February 7, 1946, printed the following form blank:

Attention: Doctors Returning From Service

What are your problems?

How can we help you?

We invite you to join our Medical Veterans' Association formed to assist the returning physician in every way possible in reëstablishing his practice.

For more information regarding our association, communicate with the Secretary, Dr. Frederick A. Bennetts, 1921 Wilshire Blvd., Los Angeles 5, Calif.

Do you need office space? The housing committee of the Medical Veterans' Association would appreciate your filling in the questionnaire appearing below in order that they may take steps to help you.

Name ....

Address ....

Telephone ....

Specialty ....

Special Attention to:

General .... ☐

Desired Location:
(Check one)
Metropolitan Area ☐
Wilshire ☐
Beverly Hills ☐
Hollywood ☐
Southwest ☐

Preferred Requirements:
1. Association ☐
2. Office space alone ☐
3. Hours (will accept)
Morning ☐
Afternoon ☐
4. Amount space desired:

Suburban:
(a) Preferred Locale ....
Building Preference: ....
Were You a Former Tenant? Yes ☐ No ☐

Please return completed questionnaire to the Housing Committee.

HOUSING COMMITTEE MEDICAL VETERANS' ASSN.
Paul D. Foster, M.D., J. Norman O'Neill, M.D., Wells C. Cook, M.D.

Home-Town Medical Care for Veterans on Trial in Two States: Michigan and California

"Home-town medical care" for veterans with service-connected disabilities is now being tried out in California and Michigan, the Veterans' Administration has advised the American Legion, which is watching the experiment with a great deal of interest.

Doctors of the California and Michigan State Medical Associations have signed contracts with the veterans' agency, General Omar N. Bradley, administrator of veterans' affairs, said. He added that doctors of North Carolina are discussing participation in the program.

At the same time the V.A. announced it was negotiating with the American Hospital Association for use of some 20,000 beds in 3,400 civilian hospitals. This plan, V.A. officials said, will extend over the nation and include the 450 civilian hospitals now under individual contract in various communities.

Local Care Possible

Once the entire program has matured, it will permit veterans to receive treatment and care for service-connected disabilities from their local doctors and hospitals instead of going to V.A. hospitals which might be outside their home communities. It will also spare excessive crowding of V.A. facilities.

For the week ending December 27, 1945, there were 1,940 veterans receiving care in civil and state hospitals, the V.A. said.

American Legion officials stated in Washington they had given no endorsement to the "home town medical care" experiment, but were watching it closely. They said they were interested in having adequate hospitals and medical facilities for veterans with service-connected disabilities. They added the Legion's basic philosophy always has been that the Federal Government should build enough veterans' hospitals, fully staffed by competent medical men, so that beds would be available for all veterans in need of treatment.

Under the new plan, the V.A. contracts for a standard of hospital service and gives the veteran with service-connected disabilities a free choice of doctors. The contracts with doctors' associations are negotiated separately.

Army Medical Library

The following additional information from a brochure, "The Most Important of the Four":

* * *

Army Service Forces, Medical Department, Major General Norman T. Kirk, the Surgeon General.

* * *

The Army Medical Library, 7th Street and Independence Ave., S.W., Washington, D. C.; Colonel Leon L. Gardner, M.C., U. S. A., the Director; Mr. Wyllis E. Wright, the Librarian.

* * *

Sponsored by the Association of Honorary Consultants to the Army Medical Library.

* * *

Association of Honorary Consultants to the Army Medical Library:

President of the Association and Chairman of the Executive Committee: Dr. John F. Fulton, Yale University School of Medicine, New Haven, Connecticut.

Vice-President: Dr. Chauncey D. Leake, University of Texas School of Medicine, Galveston, Texas.

Secretary-Treasurer: Colonel Harold W. Jones, U.S.A., Ret., Army Medical Library, Washington, D. C.

The Executive Committee: Dr. Clyde L. Cummer, Cleveland Medical Library Association, Cleveland, Ohio; Dr. Wilburt C. Davison, Duke University School of Medicine, Durham, North Carolina; Dr. Morris Fishbein, American Medical Association, Chicago, Illinois; and Major General George F. Lull, American Medical Association, Chicago, Illinois.

* * *

The late Dr. William H. Welch, eminent pathologist of Johns Hopkins University, said: "I have been asked on more than one occasion what have been the really great contributions of this country to medical knowledge. I have given the subject some thought and believe that four should be named: (1) the discovery of anesthesia; (2) the discovery of insect transmission of disease; (3) the development of the modern public health laboratory in all that the term implies; (4) the Army Medical Library and its Index-Catalogue. *This library and its catalogue are the most important of the four."*

In 1836, during Andrew Jackson's second term, Surgeon General Lovell started the small collection of books which is today known as the greatest medical research library in the world.

The Army Medical Library's collection includes 513 medical incunabula. Of some works, it has the only known copy. There is a collection of early manuscripts from European and Oriental sources and an extensive collection of rare sixteenth and seventeenth century medical works.

There are theses published at the University of Paris (considered to be the most complete collection in existence); a vast collection of vital statistics; and a medical art collection including some 10,000 items, with references to more than 50,000 portraits and illustrations.

Material of clinical importance flows into the Library from nearly every country in the world. Russian publications, Chinese periodicals, Icelandic, Turkish, Hungarian, Croation, Portuguese, Dutch, Swedish, and Spanish monographs and journals all make their contribution to the Library's collection. Over 3,500 serial titles are regularly recorded. In all there are over a million items of which more than 500 000 are bound volumes.

It has been well said that books are properly compared to tools of which the index is the handle. This wealth of medical knowledge has been made accessible through the Index-Catalogue, conceived by the first Librarian, Colonel John Shaw Billings.

Basic bibliography of medicine since 1880, the Index-Catalogue has world-wide distribution. Its most recent volume covers 6,000 medical and scientific subjects with a total of 105,000 references.

Inter-library loans, bibliographical and photoduplication services make it possible for the doctor, wherever he may be, to have at his beck and call all of the Library's resources. Through these services over a half million pages of medical information per month are distributed to all parts of the world.

Today's demands for greater medical knowledge have placed heavy responsibilities on the Army Medical Library. To meet these responsibilities and to provide proper housing for its ever expanding collection a new and larger building must be secured.

Building plans have been drawn adequate to meet these needs. The site has been approved. An organization of sufficient strength to carry forward has been planned.

The Army Medical Library looks forward to the time when it will become a part of the proposed group of cultural and research centers with the Folger Library and the Library of Congress on Capitol Hill. Thus will be provided in one central location the greatest assemblage of means for cultural research that the world has ever known.

All efforts are directed toward bringing about the success of these plans. This great medical research library must continue to build and interpret its collection in support of medical progress.

The Army Medical Library looks forward to new horizons in library service, for all who work for the betterment of mankind through the prevention of disease and the alleviation of human suffering.

U. C. Man Appointed to Veterans' Post

Dr. Karl M. Bowman, professor of psychiatry in the University of California Medical School and superintendent of the Langley Porter Clinic, has been appointed consultant in neuropsychiatry for Branch 12 of the Veterans' Administration.

In this position Dr. Bowman, an internationally known psychiatrist, will supervise neuropsychiatric activities of the Veterans' Administration in California, Arizona, and Nevada.

New Addition for Ft. Miley V.A. Hospital

A 1½-million-dollar grant for a tuberculosis addition to the Fort Miley Veterans' Hospital today headed a list of three Veterans' Administration hospital projects totaling $4,596,219 planned for the San Francisco branch area.

A 250-bed general medical hospital will be built at Fresno at a cost of $2,634,676, according to Veterans' Administration General Omar N. Bradley. Another 200-bed general hospital, to cost $2,380,440, is scheduled for Phoenix, Ariz.

Funds for construction projects have been turned over to the U. S. Army Engineers, who will supervise the building.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Warren Signs Disability Insurance Bill

Sacramento, March 5.—(UP.)—Governor Warren today signed a disability insurance bill passed by the Legislature, calling it "one of the most important bills enacted in recent years."

The measure goes into effect in May, 1947, and allows payment of regular unemployment insurance benefits to persons out of work because of illness or non-industrial injury.

Comfort for Thousands

"I believe this bill is going to bring a lot of comfort into hundreds of thousands of workingmen's homes who otherwise would be just destitute when illness strikes the breadwinner," Warren said. "I'm satisfied it's sound in principle and can be administered efficiently."

Under the measure the present 1 per cent employee payroll tax will go into a disability fund beginning May 21. Benefit payments will start a year later unless the Federal Social Security Board allows the use of taxes already paid. In that case, payments would begin this fall.

Payments range from $10 to $20 a week for 23 weeks. Some 2,500,000 persons will be covered by the system.

Paid Into Fund

Warren said that since the present payroll tax is used to support the system, "the working people of the State are not getting something for nothing. They have been paying into the fund since 1937 and have got nothing for their share."

California is the second State to try a sickness benefits system, and Warren said it is "pioneering in this field just as it did 30 years ago with industrial accident insurance."

The Governor also signed a bill setting workmen's compensation insurance benefits at $30 a week for the next two years. Payments for temporary disability were raised three years ago from $25, while permanent disability payments have remained at $25.—Los Angeles *Times*, March 6.

* * *

Governor Signs S. 40 (Shelley Bill) Setting Up a Disability Insurance System in California

Payments of sickness benefits in California under the Shelley bill was signed on March 5 by Governor Earl Warren.

The measure sets the start of payments as one year after the effective date of the act, which in turn is 90 days after the adjournment of the present legislative session. . . .

Provisions of the bill include:

1. All persons now covered by unemployment insurance are covered by the act, except—employees participating in a sick leave plan giving at least as good benefits as those in the state system can withdraw from the state system.
2. Payments would range from $10 to $20 a week for periods of nine to 23 weeks, depending on the amount of money earned during the year previous to the disability. Income of $2 000 a year qualifies an employee for maximum benefits. However, if a person draws both unemployment and sickness benefits within one year, he may get a combined total of only 35 weeks of benefits.
3. A waiting period of seven days is enforced before payments start for each illness.
4. Application for benefits will be made directly to an office of the State Department of Employment, supported by a certificate from a physician or a practitioner of a recognized healing art. The application must be renewed each week as with unemployment insurance.
5. The payments are financed from the 1 per cent payroll tax on employees. Officials estimate that payments will be around 28 million dollars a year and that income will be around 36 million dollars a year.

⁂

The bill provides for unemployment insurance benefits for persons out of work because of illness or nonindustrial injuries and for economic reasons.

A 1 per cent employee payroll tax will go into a disability fund beginning next May 21. Payments will start a year later unless the U. S. Social Security Board allows use of taxes already paid. In that case, payments would begin this fall.

Payments range from $10 to $20 weekly for nine to 23 weeks.

A person would be eligible for both unemployment and disability insurance within a year, but the combination is limited to 35 weeks.

British Medical Bill Opposed

50,000 British Doctors Raise Fund Against Socialization

London, March 8—(INS)—Some 50,000 British physicians today were reported subscribing to an $8 000 000 fund to fight the Labor Government's nationalized health service should it "conflict with the best interests of medicine."

Said the British Medical Journal:

"Whether the fight will be necessary will not be known until the contents of the (goverment) bill are revealed."

The physicians were reported considering continued private treatment of patients, in opposition to the government program, should lectures and other means fail to force modification of any aspects of the nationalized service considered objectionable.

Some $500 000 of the fund would be used to finance the propaganda campaign. The balance would compensate physicians for money lost by refusing to practice for the government.—San Francisco *Examiner*, March 9.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Los Angeles County Allocates $1,500,000 for Branches of Los Angeles County General Hospital

In a move to ease a critical shortage of hospital beds in Los Angeles county which is threatening public health, the Board of Supervisors on February 19, earmarked $1 500 000 of State funds allocated to this county under the Field bill be set aside to finance a proposed $3,000,000 program of branch hospitals.

At the same time, the board adopted a motion by Supervisor Raymond V. Darby to instruct County Manager Wayne R. Allen to negotiate with the Federal Government for acquisition by the county of the U. S. Army Port of Embarkation Hospital at Torrance so that 300 patients from the Los Angeles County General Hospital can be moved there by April 1.

The proposed program of branch units of the Los Angeles County General Hospital calls for the Torrance institution to accommodate Long Beach and the harbor area, another to be built in the San Fernando Valley and a third to be constructed in Pomona Valley. The three units are to be the first in the branch hospital program which Allen was asked to submit to the supervisors.

In addition to the $1,500 000 of State funds a similar amount will be raised by direct tax levy or by a bond issue to be submitted to the voters next November to match the State funds. Under the proposal each branch hospital would accommodate from 250 to 300 patients and cost an average of $1 000 000 a unit to construct.

Superintendent of Charities Arthur J. Will told the supervisors General Hospital now has 3,279 patients or 279 more than the largest load in its history. He declared there is immediate need for 1,600 additional beds in the hospital.

Director of State Hospital Survey Named

Dr. Philip K. Gilman of San Francisco, has been named to conduct a State-wide survey of California hospitals as authorized in a bill recently signed by Governor Warren.

Dr. Gilman was appointed by Dr. Wilton L. Halverson, State public health director.

The survey was approved by the recent Legislature at the request of the Governor. It will permit California to share in a Federal aid program for the extension of hospital facilities An appropriation of $25 000 was made to carry on the survey. Coördination of hospital services within and between communities is an objective of the survey.

Blue Cross Plan Is Making Gains in Southern California

During the past year, members of the nonprofit Southern California Blue Cross Plan, received a total of 107,241 days of hospital care which, at current hospital rates, represented a saving of $1,117,077.30, according to Ralph Walker, executive director.

During the same period, membership in the plan increased 51½ per cent over 1944 and five new additions were made to the member-hospital roster, Walker said.

For the first time in the history of the organization, community-wide enrollments were recently conducted in Alhambra and Ventura during which self-employed persons were eligible for membership. A similar campaign is now under way in Bakersfield.

According to Walker, Blue Cross was founded in 1937 by the Hospital Council of Southern California so that employed persons could prepay the cost of hospital bills on a voluntary, nonprofit basis.

At the present time there are 350,000 members in California, while nationally the figure is now close to the 20,000,000 mark, with an average work-day growth of 17,000.

A total of 81 hospitals comprise Blue Cross in the southern area, and care is rendered by them on a service rather than a reimbursement basis.

During the year, Blue Cross contracts have been liberalized to cover all known diseases and injuries, Walker said.

To keep pace with the rapid growth of the plan, branch offices have been established in San Diego, Santa Barbara, Fresno and Bakersfield. Headquarters is located at 743 South Grand View Street, Los Angeles.

American Hospital Association Prints Important Brochures on Hospital Organizations and Planning

To offer expert guidance to the many organizations and civic groups now contemplating the establishment of new hospital facilities in their communities, a group of articles reprinted from the 1945 Hospital Review is now available from the American Hospital Association. Discussions of important phases of hospital organization and construction, published in three pocket-sized booklets, are entitled:

"Measuring the Community for a Hospital" (early considerations in planning).

"Organization of the Medical Staff."

"The Governing Board of the Hospital."

Prepared by Warren P. Morrill, M.D., director of research of the Association, each of the treatises was submitted for criticism to more than thirty leaders in the professional fields, and various points of view were incorporated. A fourth article, "The Administrative Aspects of Hospital Planning," is designed to assist the building committee when it begins work with the architect. This article, though unavailable in reprint form, may be found in the complete Book I of the 1945 Hospital Review, "The Individual Hospital."

"Measuring the Community for a Hospital" is available through the Department of Public Relations, American Hospital Association, Chicago 10, for $.25 per single copy and $.15 per copy in quantities of five or more. "Organization of the Medical Staff" and "The Governing Board of the Hospital" may be ordered at $.20 per single copy, or $.12 per copy in quantity.

The Blue Cross Plan

Close to sixteen per cent of the people in the United States are members of the Blue Cross hospital plan. John R. Mannix Chairman of the American Hospital Association's Blue Cross plan commission, gave these figures recently in Washington. (Weekly Underwriter, January 19, 1946).

> . . . Blue Cross hospital-service organizations now have 20,000,000 members, compared with 5,000,000 in 1939. He said that it was reasonable to predict "complete national coverage within the next five years."

Complete national coverage would mean the operation of the plan in each of the 48 states. At the present time, five states lack the plan: Arkansas, Idaho, Mississippi, South Carolina and Wyoming. Voluntary methods for prepaid hospital care thus seem to be increasingly popular.

Commission on Hospital Care Report

Expansion of services of the large general hospital to include tuberculosis and nervous and mental care may well take place in the future, suggested Arthur C. Bachmeyer, M.D., at the Midyear Conference February 8 and 9 of the American Hospital Association. The director of study of the Commission on Hospital Care,—an independent public service committee studying hospital facilities in the United States and initiated by the Association,—Dr. Bachmeyer spoke before officers of hospital organizations of the United States and Canada. The conference was held in Chicago's Drake Hotel.

Discussions of relationships of the general hospital to all types of health care bring the following considerations to the fore, Dr. Bachmeyer told the conferees:

The advisability of constructing new tuberculosis facilities adjacent to and operated in conjunction with large general hospitals.

The provision of facilities in large general hospitals for diagnosis of nervous and mental patients, and for treatment of those patients not in need of long-term institutional care.

The feasibility of expanding the functions of special communicable disease hospitals now operated by cities, towns, and villages to include all types of illness.

The possibility of the maintenance of nursing schools by large institutions only, which would affiliate for rural hospital experience with hospitals in smaller communities; improved hospital care for Negroes; and the computation of the need for hospital beds in local or statewide areas based upon the ratio between the death rate and the days of hospital care, were other proposals related to the group by Dr. Bachmeyer.

"Action on state surveys of hospital facilities has now been taken in every state and in the District of Columbia," he said. "Thirty-one surveys are now actually in progress.

"Because developments have come rapidly, the Commission feels that it can complete its work by October 1, 1946, the termination date of the original two-year allotted period," stated Dr. Bachmeyer.

It is expected that the Commission's report will be published shortly thereafter.

Chicago Hospitals Crowded

More than twice as many patients were handled by the hospitals of Chicago and Cook County in 1944 than 10 years earlier. Daily occupancy rose from over 5,000 in 1934 to 11,461 in 1944. An official of the American Hospital Association for Chicago and Cook County stated (Chicago Tribune, January 16, 1946) that:

> Such institutions are more crowded today than at any time during the last 10 years, principally because more persons now are able through insurance or greater earning power to pay for such hospital care.

The significance of this statement lies in the fact that a similar situation exists throughout the country. Whatever the reason for the increase, the fact remains that the hospitals are operating at close to capacity. Should the nation adopt compulsory health insurance, additional millions of people would be eligible for hospital care, and until present facilities are greatly expanded, there simply would not be room for more patients.

V.A.-C.P.S. Contract. Veterans' Administration officials, California Medical Association executives and medical and executive personnel of the California Physicians' Service shown in the San Francisco office of Col. T. J. Cross, acting deputy administrator, where the V.A.-C.P.S. contract for the immediate out-patient care of all California veterans was given final approval.

Standing, left to right, Dr. A. E. Larsen, medical director C.P.S.; Richard Lyon, operations manager C.P.S.; Dr. John W. Nielsen, V.A. liaison medical officer, Los Angeles; Col. James G. Donnelly, manager, San Francisco V.A. hospital; Robert Shields, manager, San Francisco regional office; Raymond H. Castro, finance officer, San Francisco regional office; Col. C. E. B. Peeke, V.A. director of public relations; Dr. Chester L. Cooley, secretary C.P.S.; Col. F. G. Bell, director of medical service V.A.; Col. Charles W. Colebaugh, chief, out-patient and reception service, Los Angeles V.A. hospital; Maude Maxwell, supervisor medical dept., Los Angeles; Dr. William Gardenier, assistant medical director, C.P.S., Los Angeles area; Lt. Col. Darling, V.A. liaison medical officer, San Francisco; W. M. Bowman, executive director, C.P.S. Seated, Maj. L. E. Briscoe, chief, out-patient and reception service, Fort Miley, V.A. center, San Francisco, and Col. Cross.

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California Physicians' Service—Veterans' Administration Program

(Release for Publication from California Physicians' Service on March 21, 1946)

INSTRUCTIONS

There will be mailed to each C.P.S. physician a booklet containing forms, known as VET 52, which will be used to determine eligibility for treatment. This form represents a request for authority for treatment.

(1) The first step in the care of the veteran is to have this form completed in duplicate in all cases.

(2) This form is a request for authority for treatment. It should be mailed to C.P.S. the day it is completed.

(3) Send both copies to California Physicians' Service: North of Fresno: mail to 153 Kearny Street, San Francisco 8, California.

Fresno South: mail to 743 South Grandview, Los Angeles 5, California.

(Physicians residing in Kings, Tulare and Fresno counties: Please send all forms and communications relative to the Veterans' Program to 153 Kearny Street, San Francisco 8, California, because these counties are in the northern region of the Veterans' Administration. For regular C.P.S. business under the Commercial Program in these counties the forms will continue to be sent to 743 South Grandview Street, Los Angeles 5, as formerly.)

(4) Upon receipt of this form, C.P.S. will check eligibility for service with the Veterans' Administration. As soon as this can be determined, you will be notified of acceptance or rejection of treatment by return mail service.

TREATMENT

If the case is accepted, you will receive notice of the extent of treatment authorized, on a second form which will be prepared in the C.P.S. office. Upon receipt of this second form, the physician will complete the authorized service, and when this is completed, the form is to be mailed to C.P.S. as soon as possible. If further treatment, beyond that which has been authorized, is indicated, there is a place on the form to request it. Please always indicate the number of visits and any special service such as x-ray, lab, etc., which you feel may be required. When this form is completed and is received in the C.P.S. office, it represents your full report as well as your bill for services. A check for these services will be mailed to you by C.P.S.

Any service rendered by you which is not included in the authorization will not be allowed by the Veterans' Administration.

General Information Regarding Benefits Under C.P.S.-Veterans' Administration Program

In order to receive care under this program a veteran must have previously filed a claim with the Veterans' Bureau. When such a claim has been recorded, the veteran is entitled to care by the physician of his own choice, as follows:

(1) Males:

(a) Service incurred disabilities.

(b) Inter-current illnesses when retarding recovery or aggravating a service connected disability.

(c) Veterans attending school—high school, university, etc.—under the G.I. Bill of Rights, are only entitled to treatment for service connected disabilities as described in subparagraphs (a) and (b) above.

(d) Veterans receiving Vocational Rehabilitation Training are covered for necessary treatment for any and all conditions which may interrupt training, regardless of service connection. Arrangements have been made to have Vocational Training officers give veterans taking this training a letter explaining their status. This letter should be attached to the initial report form. It will expedite issuing proper authorization.

Females:

(a) Females are entitled to the same benefits as described above for the male.

The above services are available to veterans who do not live within a reasonable distance of or have easy access to a Veterans' Administration Out-Patient office or hospital, with the exception that house visits when necessary, may be provided by the physician of choice, regardless of the distance from the Veterans' Administration Out-Patient office or hospital.

(2) Hospital Care may be authorized in private hospitals for service connected disabilities, if requested by you and approved by the Veterans' Administration when the condition of the veteran precludes travel, or when no bed is available in a Veterans' Administration hospital, with the exception that female veterans are entitled to hospitalization in private hospitals for non-service connected disabilities, if emergent except normal child-birth, and no bed is available in a Veterans' Administration hospital or the condition of the patient precludes travel.

(3) X-ray and laboratory procedures will be authorized in connection with the above services if requested by you and authorized by the Veterans' Administration.

Important: A complete report of the findings of such procedures, should accompany your bill. Your own stationery or the reverse side of the treatment form may be used for this purpose if performed in your office. If sent out to other laboratories or radiologists, they will submit their bill directly to C.P.S. on their own stationery, and attach a copy of their findings.

(4) Drugs provided by you will be paid for in emergencies when itemized and an extended cost given in the space provided. Thereafter the patient should be given a prescription and instructed to send it to the Veterans' Hospital in San Francisco or Los Angeles. The prescription will be filled there and mailed to the patient.

It is requested that in so far as possible prescriptions given to the veterans for compounding at Veterans' Administration hospitals be limited to U.S.P., N.F. and Council-Accepted Drugs.

Prosthetic appliances and other materials may be paid for when itemized.

Examinations for Ratings

In addition to treatment for illnesses, general and special examinations for rating purposes will be requested by the Veterans' Administration. The doctor will be provided with the proper forms, and the veteran will be instructed to contact your office for an appointment to have the examination completed. The physician may bill C.P.S. by use of the regular C.P.S. Form No. 9, in duplicate, or on his own stationery in duplicate.

Note: In all examinations and treatments, please do not discuss with the veteran the probable degree of disability rating, or the merits of one already given by the Veterans' Administration. It is also asked that the physician not discuss the evaluation or legitimacy of benefits for treatment. These matters are purely for the Veterans' Administration to decide after review of the veteran's record. At no time should the physician disclose to the veteran information regarding the contents of his present or previous medical record.

Important: The amount of information required under this program must necessarily be more complete than under the regular C.P.S. Commercial Program.

This is necessary because all reports will become part of the veteran's permanent record. They will be the basis upon which all his rights (present and future) as a veteran, will be determined. For this reason, may we urge that all reports be complete and accurate.

Our contract provides that incomplete reports will be returned to the physician for further information at no additional expense to the Veterans' Administration.

(Signed) Lowell S. Goin, M.D., *President.*
California Physicians' Service.

COMMITTEE ON POSTGRADUATE ACTIVITIES

Los Angeles Physicians Invited to Attend a Series of Four Medical Lectures at U.C.L.A.

Members of the Los Angeles County Medical Association are cordially invited to attend a series of four lectures to be given as a part of the refresher courses now being offered by University of California of Los Angeles at Westwood Village.

The first series of lectures will be given by Doctor Arthur Grollman of Dallas, Texas, on the evenings of March 12, 13, in the Physics-Biology Building. Lectures begin promptly at eight o'clock.

The second series will be presented by Doctor Russell L. Cecil of Cornell University and will be given on the evenings of April 23, 24, beginning promptly at eight o'clock.

The Los Angeles County Medical Association is cooperating in making these lectures available at no cost to members. Admission will be by membership card. Further details follow:

Among prominent visiting lecturers scheduled to participate in the medical refresher courses now being offered by University of California Extension are Dr. Russell L. Cecil, Professor of Clinical Medicine, Cornell

University, and Dr. Arthur Grollman, of the Department of Experimental Medicine, Southwestern Medical College, Southwestern Medical Foundation, Dallas, Texas.

Dr. Grollman, who received his A.B., Ph.D., and M.D. degrees from Johns Hopkins University, was Associate Professor of Pharmacology and Experimental Therapeutics in the Johns Hopkins Medical School from 1932 to 1941. From 1941 to 1945 he was Resident Professor of Medicine at Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, North Carolina. Dr. Grollman will present two lectures on the Los Angeles campus of the University of California. The first, to be given from 8:00 to 10:00 p.m. on the evening of March 12, 1946, is entitled: "Clinical Aspects of Thyroid Disease." On March 13, from 8:00 to 10:00 p.m., Dr. Grollman's topic will be: "Recent Experimental Studies in Hypertension."

Dr. Cecil has been Professor of Clinical Medicine at Cornell University since 1933. He was President of the American Rheumatism Association in 1937-38 and of the New York Rheumatism Association in 1942-43. He is the author of *Diagnosis and Treatment of Arthritis,* 1929, 1936, and editor of *A Textbook of Medicine by American Authors,* 1927, 6th edition, 1943. Dr. Cecil will lecture on two consecutive evenings, April 23 and 24, from 8:00 to 10:00 p.m., on the Los Angeles campus of the University of California. He will speak on the general subject of "Arthritis," with special emphasis on rheumatoid and hypertrophic arthritis.

Seventh Annual Los Angeles Postgraduate Symposium

The Seventh Annual Postgraduate Symposium for physicians of the Medical, Dental and Pharmaceutical Association of Southern California, in coöperation with the California Tuberculosis and Health Association, the Los Angeles County Tuberculosis and Health Association, and the Los Angeles Heart Association, will be held in Los Angeles, March 10 through the 13.

A public meeting, concerning itself with community public health, will formally open the symposium on Sunday, March 10, at 3:15 p.m., at the Zion Hill Baptist Church, East Fifty-first and McKinley Streets.

Dr. Louis J. Regan, president of the Los Angeles County Medical Association, will give the symposium keynote speech at a stag dinner for members of the medical profession on the evening of the opening day at the Crystal Palace Tea Room at 4818 South Avalon Boulevard. Dr. Reginald Smart will speak on behalf of the tuberculosis associations.

Beginning Monday, March 11, and following through Wednesday, March 13, the symposium will concern itself with tuberculosis, neuro-psychiatry, obstetrics, syphilis, and a cardiac clinical conference. Out-of-state physicians leading the discussions will include:

Dr. W. A. Beck, fellow of the American College of Chest Physicians, Nashville, Tenn.;

Dr. H. J. Erwin, member of the American Board of Psychiatry and Neurology, St. Louis, Mo.; and

Dr. P. M. Santos, diplomate, American Board of Obstetrics and Gynecology, Chicago, Ill.

Local physicians leading the discussions will be Dr. Leo Tepper, medical director of Olive View Sanitorium; Dr. John F. Flynn, medical director of the Los Angeles County Rapid Treatment Center; Dr. A. M. Roberts, president of the Los Angeles Heart Association.

Sessions will be held at the University of Southern California, Los Angeles General Hospital, Olive View Sanitorium, and Los Angeles County Rapid Treatment Center.

C.M.A. CANCER COMMISSION

California and the Annual Drive of the American Cancer Society

The American Cancer Society will stage its annual drive for contributions during the month of April. The goal is $12,000,000, and the California quota is $854,000. The California division of the American Cancer Society will look to the medical societies to approve and add their support to this campaign.

The Cancer Commission of the California Medical Association urgently requests the coöperation of county societies in this project. Sixty per cent of all the money raised in California will remain here and will be used for cancer work in this State. Of the 40 per cent that goes to the National Society, 15 per cent is used for their program of publicity and education, while 25 per cent will be spent for research in cancer under the direction of the National Research Council that controlled all of the Government research during the war. If California meets the goal of $854,000, one-half million dollars will be spent for cancer control and the care of cancer patients in this State. The Council of the C.M.A. has asked what you will do with the half-million dollars. The answer to that question is the reason why the members of the county medical society should support the April drive

Funds will be needed and will be spent if available for—

1. To provide added facilities and follow-up work in approved cancer clinics.
2. To assist in the formation of new approved cancer clinics wherever feasible.
3. To supply hospital beds for needy cancer patients during treatment.
4. Transportation and surgical supplies for cancer patients.
5. Terminal hospital beds for advanced cancer cases.
6. To make the Pananicolaou test for cancer of the uterus available by supporting centers in Los Angeles and San Francisco.
7. To finance refresher courses for physicians.
8. To educate the public regarding the danger signals of cancer and the need for immediate treatment.

There are three important ways in which the county medical societies can assist in this cancer campaign.

1. Your patients will inquire about the campaign. Tell them that it is worthwhile and give the campaign a sincere enthusiastic boost.

2. The local Field Army will need representatives of the county medical society on their executive committee to advise and give them moral support. The county society should see that they have interested energetic members on this executive committee.

3. The local Field Army will need speakers on cancer topics for the campaign. These should come from the medical society.

All three of these services are of vital interest to the success of the campaign for the public looks to your medical judgment to determine their individual support.

Cancer is the second highest cause of death in this State. It is the No. 1 Public Enemy because of the tremendous suffering involved. We have approximately 35,000 cancer patients in California with an annual death rate of more than 11,000. The cure and relief of these patients should have our first interest and energetic support.

The Cancer Commission of the C.M.A. can assure you that the money collected by the American Cancer Society will be wisely, effectively and impartially spent throughout the State to assist the greatest possible number of cancer patients. Because of the great need and this opportunity to finance the work in cancer control, the Commission recommends and requests your support.

* * *

(Note. Above information was sent to C.M.A.'s component county medical societies by Lyell C. Kinney, M.D.,

U. S. Cancer Group Founder Dies at 80

San Diego, Feb. 24.—(AP.)—Frederick L. Hoffman, 80, former vice-president and consulting statistician of the Prudential Life Insurance Company and founder of the American Society for Control of Cancer, died today.—San Francisco *Examiner*, February 25.

(COPY)

79th Congress: 1st Session, H. R. 4502

IN THE HOUSE OF REPRESENTATIVES

On October 25, 1945, Mr. Neely introduced the following bill; which was referred to the Committee on Foreign Affairs.

* * *

A BILL

To authorize and request the President to undertake to mobilize at some convenient place in the United States an adequate number of the world's outstanding experts, and coördinate and utilize their services in a supreme endeavor to discover means of curing and preventing cancer.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the President is hereby authorized and requested to undertake, in whatever manner he may deem most appropriate, to mobilize at some convenient place in the United States an adequate number of the world's outstanding experts, and coördinate and utilize their services in a supreme endeavor to discover means of curing and preventing cancer; and to take any additional action that he may consider necessary or proper to achieve the desired result.

SEC. 2. The sum of $100,000,000 is hereby authorized to be appropriated to enable the President to carry out the provisions of this Act.

"All Out Against Cancer"

In *Collier's* of February 23, 1946, appeared an interesting article by Hannah Lees, under the caption, "All Out Against Cancer." The article was well illustrated and may be of interest to medical as well as lay readers.

Dr. Robert S. Stone Appointed to Cancer Council

Dr. Robert S. Stone was appointed on January 24, by Surgeon General Thomas Parran to a three-year term on the National Advisory Cancer Council, according to Associated Press.

Dr. Stone is a professor of roentgenology at the University of Chicago School of Medicine.

Cancer of Stomach—Mass Cancer X-Rays Found Unprofitable

Mass x-ray examination of the general population in search of stomach cancer is not profitable, it is indicated in a study by radiologists in the University of California Medical School.

The doctors conducted the survey in an attempt to determine whether or not mass surveys, such as those conducted for tuberculosis, would be useful in finding early cases of cancer.

Five hundred men above the age of 45, all of them free of any digestive complaints, were given x-rays examinations of the stomach. Not a single case of stomach cancer was found, and there were only three certain cases with other stomach disorders, such as ulcer.

The doctors pointed out that their rigid selection of candidates excluded those with the slightest symptoms, and they warned that the study in no way detracts from the view that even mild dyspepsia in older persons demands prompt medical investigation.

They also said that persons with pernicious anemia, which predisposes to stomach cancer, should have x-ray examinations.

The survey was conducted by Dr. Morris E. Dailey, clinical instructor in medicine, and Dr. Earl R. Miller, associate professor of radiology.

Cancer Clinic

Sacramento County Division American Cancer Society, is establishing a cancer clinic in Sacramento, with the first clinic to be held March 5, in Sacramento County Hospital.

X-ray equipment and other facilities of the clinic are to be made available to the public without charge and the clinic is to be staffed with specialists in blood, surgery, radium, x-rays, radiology, pathology, and other medical specialties.

All three of the major hospitals in Sacramento—Mercy, Sutter, and Sacramento—are to participate in the program. . . .

The Sacramento Cancer Society during the last year raised more than $5,000 to finance cancer prevention and control, and the society will finance the x-rays, equipment and drugs for the clinic. . . .

C.M.A. Cancer Commission

The State office will shortly receive the minutes of the meeting of the California division, but for your information the following is the outline of what was done at a recent meeting of the Cancer Commission of the California Medical Association, Dr. Lyell C. Kinney, 1831 Fourth Street, San Diego, Chairman:

1. Adoption of a constitution.
2. Discussion of proposed by-laws.
3. Adoption of a financial policy for the county branches.
4. Discussion of a request from Dr. Hunt and U. C. for $6,500.00 to inaugurate the work on the Papanicolaou smear. This was authorized subject to conditions to be approved by Drs. Rinehart and Wood.
5. Authorization of $1,500.00 subsidy to the cancer clinics about to be organized in Sacramento.
6. Discussion of the expenditure of the proposed $800,000.00 which is our quota for next year. Enclosed is an outline of the facts accepted in that discussion.

The Cancer Commission spent most of its time on the report to the Council regarding "detection clinics." The Commission also adopted a "minimum standards" to be submitted to the Council if the report is approved. Dr. Dobson of Stanford discussed the progress on the "Cancer Manual," on which he is chairman of the editorial committee. The Commission discussed and acted on the problems of the pre-convention conference.

Otto F. Müller (1730-1784).—The first attempt at the classification of the bacteria and protozoa, which Linnaeus had grouped under the vague genus "chaos," was made by Otto F. Müller. This work of bacteriological interest covered a period of twenty years, and was published posthumously in 1786. Some of the nomenclature is still employed today, "Bacillus" and "spirillum" date back to Müller, though they do not entirely retain their original significance.

COMMITTEE ON MEDICAL ECONOMICS

A.M.A.'s Nationwide Prepayment Program for Medical Care of the American People

Council on Medical Service and Public Relations
American Medical Association

Note.—The statement that follows indicates the official actions taken by the constituted authorities of the American Medical Association concerning prepaid medical care plans:

Work has begun already by the Council on Medical Service and Public Relations to put into effect the nationwide prepayment program for medical care of the American people. This program was presented February 17 to the American public through the press and over the radio by the Board of Trustees following joint action by the Council on Medical Service and Public Relations and the Board of Trustees in accord with the resolution passed by the House of Delegates last December. Work on this program is to be coördinated closely with the activities of the Associated Medical Care Plans, Inc., an organization of prepayment plans, just established.

The Board of Trustees has established under the Council on Medical Service and Public Relations a Division of Prepayment Medical Care Plans with a director and a staff who will administer the activities of the Council on Medical Service and Public Relations related to the promotion and development of medical care plans in all the states.

* * *

DIGEST-STATEMENT OF RECOMMENDATIONS OF THE COUNCIL AS APPROVED BY THE BOARD OF TRUSTEES

The Council on Medical Service and Public Relations recommends the employment of a Director of its Division of Prepayment Medical Care Plans and the necessary staff. It is recommended that the Council appoint an Advisory Committee representing medical care plans and their associations.

The Council has determined standards for medical care plans. Plans which meet these standards shall be entitled to the use of the Council Seal during the period of their approval.

The Director of the Division of Prepayment Medical Care Plans of the Council on Medical Service and Public Relations with his staff and with the assistance and coöperation of the Advisory Committee the State Medical Societies and the Association of Medical Care Plans shall be available to assist in developing plans, increasing the number of persons covered by already existing plans and facilitating reciprocity among them.

The Council believes that responsibility for the development of medical care plans rests with state and county medical societies. Stimulation, coördination and federation of such plans under the instructions of the House of Delegates is deemed to be the function of the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association.

The duty of the Advisory Committee shall be to advise the Director of Prepayment Medical Care Plans and the Council on the methods of implementing the program and, on approval of the Council, the Director of Prepayment Medical Care Plans will undertake the functions described in paragraph 3.

The Advisory Committee shall consist of five members, appointed for one year. For the first year it is suggested that the following comprise the committee: Mr. Jay Ketchum, Dr. F. Feierabend, Dr. Herbert Bauckus, Mr. William Bowman and Mr. Charles Crownhart.

A tentative cost of this program is estimated at $50,000 for the first year.

Statement of A.M.A. Trustees and Council on Medical Service, re Voluntary Prepayment Sickness Plans

The Board of Trustess of the American Medical Association and the Council on Medical Service of the American Medical Association at a meeting recently completed in Chicago have taken a long step toward protection of the American people against the costs of sickness through participation in a voluntary prepayment sickness plan now developed under the authority of the American Medical Association.

* * *

The fundamental step in the development of this plan was the establishment of standards of acceptance for medical care plans which have the approval of the Council on Medical Service of the American Medical Association. Any plan which meets the standards of the Council will be entitled to display the seal of acceptance of the American Medical Association on its policies and on all of its announcements and promotional material. In order to qualify for acceptance, the prepayment plan must have the approval of the state or county medical society in the area in which it operates. The medical profession in the area must assume responsibility for the medical services included in the benefits. Plans must provide free choice of a qualified doctor of medicine and maintain the personal, confidential relationship between patient and physician. The plans must be organized and operated to provide the greatest possible benefits in medical care to the subscriber.

* * *

Medical care plans may be in terms of either cash indemnity or service units, with the understanding that benefits paid in cash are to be used to assist in paying the costs incurred for medical service. The standards also include provisions relative to the actuarial data that are required, systems of accounting, supervision by appropriate state authorities and periodic checking and reporting of the progress of the plan to the Council.

* * *

Coincidentally with the announcement of these standards of acceptance, there was organized, as a voluntary federation, an organization known as "Associated Medical Care Plans, Inc." This independent association will include as members all plans that meet the minimum standard of the Council on Medical Service of the American Medical Association. The Associated Medical Care Plans will undertake to establish coördination and reciprocity among all of these plans so as to permit transference of subscribers from one plan to another and use of the benefits in any state in which a subscriber happens to be located. Under this method great industrial organizations with plants in various portions of the United States will be able to secure coverage for all of their employees. Moreover, it will be possible for the Veterans' Administration, welfare and industrial groups as well as government agencies, to provide coverage for the people in any given area through a system of national enrollment. In addition, the Associated Medical Care Plans, Inc., will undertake research and the compilation of statistics on medical care, provide consultation and information services based on the records of existing plans and engage in a great campaign of public education as to the medical service plan movement under the auspices of state and county medical societies.

* * *

The Board of Trustees of the American Medical Association also announced the establishment under its Council on Medical Service of a Division of Prepayment Medical Care Plans with a director and a staff who will administer the activities of the Council on Medical Service related to the promotion and development of medical care plans in all of the states.

In announcing its proposals for a nation-wide provision of sickness insurance on a mutual nonprofit basis, the Association through its President and the Board of Trustees authorizes the publication of its complete health program with the ten points, which include the development of services in the field of preventive medicine, maternal and child health, voluntary prepayment plans for protection against the costs of sickness, compensation for loss of wages due to illness, the care of the veteran and the development of a high standard of housing, nutrition, clothing and recreation.

The American Medical Association last June through its Board of Trustees and Council on Medical Service announced a 14-point program to improve the health and medical care situation in the United States. In October, 1945, the interpretation of these 14 points and methods of implementation were adopted by the Council on Medical Service. In December, 1945, the House of Delegates approved the whole program, suggested its rearrangement and directed the Board of Trustees to keep the program constantly up to date so that it will stay at least even with and, if possible, a step ahead of the needs of the public.

* * *

With this in mind the Board of Trustees has adopted a restatement of the 14-point program, which clarifies still further the position of the American Medical Association on some of these points and brings into the program more definitely such matters as maternal and child welfare, medical research, the medical care of the veteran and the part to be played by the voluntary health agencies.

This restatement follows:

NATIONAL HEALTH PROGRAM OF THE AMERICAN MEDICAL ASSOCIATION

1. The American Medical Association urges a minimum standard of nutrition, housing, clothing and recreation as fundamental to good health and as an objective to be achieved in any suitable health program. The responsibility for attainment of this standard should be placed as far as possible on the individual, but the application of community effort, compatible with the maintenance of free enterprise, should be encouraged with governmental aid where needed.

2. The provision of preventive medical services through professionally competent health departments with sufficient staff and equipment to meet community needs is recognized as essential in a health program. The principle of Federal aid through provision of funds or personnel is recognized with the understanding that local areas shall control their own agencies as has been established in the field of education. Health departments should not assume the care of the sick as a function since administration of medical care under such auspices tends to a deterioration in the quality of the service rendered. Medical care to those unable to provide for themselves is best administered by local and private agencies with the aid of public funds when needed. This program for national health should include the administration of medical care including hospitalization to all those needing it but unable to pay, such medical care to be provided preferably by a physician of the patient's choice with funds provided by local agencies with the assistance of Federal funds when necessary.

3. The procedures established by modern medicine for advice to the prospective mother and for adequate care in childbirth should be made available to all at a price that they can afford to pay. When local funds are lacking for the care of those unable to pay, Federal aid should be supplied with the funds administered through local or state agencies.

4. The child should have throughout infancy proper attention including scientific nutrition, immunization against preventable disease and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child care and infant welfare stations administered under local auspices with support by tax funds whenever the need can be shown.

5. The provision of health and diagnostic centers and hospitals necessary to community needs is an essential of good medical care. Such facilities are preferably supplied by local agencies, including the community, church and trade agencies which have been responsible for the fine development of facilities for medical care in most American communities up to this time. Where such facilities are unavailable and cannot be supplied through local or state agencies, the Federal Government may aid, preferably under a plan which requires that the need be shown and that the community prove its ability to maintain such institutions once they are established. (Hill-Burton bill.)

6. A program for medical care within the American system of individual initiative and freedom of enterprise includes the establishment of voluntary nonprofit prepayment plans for the costs of hospitalization (such as the Blue Cross plans) and voluntary nonprofit prepayment plans for medical care (such as those developed by many state and county medical societies). The principles of such insurance contracts should be acceptable to the Council on Medical Service of the American Medical Association and to the authoritative bodies of state medical association. The evolution of voluntary prepayment insurance against the costs of sickness admits also the utilization of private sickness insurance plans which comply with state regulatory statutes and meet the standards of the Council on Medical Service of the American Medical Association.

7. A program for national health should include the administration of medical care, including hospitalization, to all veterans, such medical care to be provided preferably by a physician of the veteran's choice with payment by the Veterans' Administration through a plan mutually agreed on between the state medical association and the Veterans' Administration.

8. Research for the advancement of medical science is fundamentally in any national health program. The inclusion of medical research in a National Science Foundation, such as proposed in pending Federal legislation, is endorsed.

9. The services rendered by volunteer philanthropic health agencies such as the American Cancer Society, the National Tuberculosis Association, the National Foundation for Infantile Paralysis, Inc., and by philanthropic agencies such as the Commonwealth Fund and the Rockefeller Foundation, and similar bodies have been of vast benefit to the American people and are a natural outgrowth of the system of free enterprise and democracy that prevail in the United States. Their participation in a national health program should be encouraged and the growth of such agencies when properly administered should be commended.

10. Fundamental to the promotion of the public health and alleviation of illness are widespread education in the field of health and the widest possible dissemination of information regarding the prevention of disease and its treatment by authoritative agencies. Health education should be considered a necessary function of all departments of public health, medical associations and school authorities.

A.M.A.'s Medical Plan

The American Medical Association's proposal for a national voluntary plan for medical care is a positive move on the part of the profession to head off State and Federal "social medicine" programs

Dr. Roger I. Lee, president of the A.M.A., explains that any medical care plan now functioning in local communities which meets A.M.A. standards and has received medical society approval may be accepted under the program. In the proposed national voluntary federation of local medical care groups the advantages to insured members would include the privilege to transfer from one community group to another and other reciprocal benefits

The A.M.A.'s program should win wide support among the profession and the public—Los Angeles *Times.*

You May Be Next

Seldom has any single group within the United States been threatened with the degree of political coercion and oppression that now threatens the medical profession.

In spite of protestations to the contrary, the President's plan for a centralized Government-controlled medical system cannot be other than oppressive. It is to be financed by compulsory contributions, directed by overhead authority and subject to all the evils of politics. Doctors oppose such a system because of the destruction it would wreak on medical standards. However, more than medical standards should be considered. The public will do well to ponder the potentialities of a program that would put tens of thousands of doctors under the heel of Federal authority, against their will. If it can be done in the field of medicine, it can be done to other groups.

If this country is to have a sound, progressive medical system it must respect the professional judgment of medical men in matters pertaining to medicine, and also respect their rights as a minority group.—Visalia *Times Delta,* February 8.

Compulsory Health Insurance and Chambers of Commerce

Unsound and undesirable are the words used by Clarence A. Jackson, Executive Vice-President of the Indiana State Chamber of Commerce, to describe the pending compulsory health insurance proposals. The system is unsound, Jackson said, because there is lack of balance between cost and benefits. Declaring that such a program would bankrupt the nation, Jackson continued (*Christian Science Monitor,* January 9, 1946)

> A system which will permit a person to draw a full year of unemployment and sickness benefits totaling $1,560 on the basis of earnings of only $570, as does the Wagner-Murray-Dingell plan, can hardly be said to encourage an industrious attitude . . .

Further, the system is undesirable, because

> . . . it would be destructive both to the moral fiber and the freedom and economic security of the American people. It would clamp down Federal regimentation on our lives . . .

Voluntary plans are favored by Jackson, who is also a member of the Social Security Committee of the U. S. Chamber of Commerce. Of these voluntary plans he says in the same article:

> Progress being made under the existing system of private practice by doctors and voluntary hospital and sickness insurance plans, combined with present continually expanding public systems of free medical and hospital care facilities for those unable to pay for the services themselves, is outstanding.

These views are said to be shared by the Indiana Chamber of Commerce and similar organizations in other states. In other words, giving the voluntary systems a chance before deciding that compulsion is necessary.

Social Security—What Will It Cost?

More and more, cost looks like the tail that will wag the dog in the social security proposals. The fact that the sponsors and advocates have not come forth with an itemized estimate of the future bill has not deterred private sources from speculating on this all-important aspect of the security program. At the recent meeting of the Church Pensions Conference in New York, its actuary, George A. Huggins, had this to say: (*Christian Science Monitor,* December 1, 1945)

> The experts of this special (House) committee have indicated that "an aggregate payroll tax of 8 to 10 per cent is necessary to pay benefits for which the Government is already obligated" and that "enlargement of the program, as envisioned by the Wagner-Murray-Dingell bill, would probably serve to increase tax requirements to not less than 12 per cent, and possibly to 14 or 15 per cent." The experts have even intimated that there may be needed substantial subsidies from the Treasury in addition to a 14 or 15 per cent tax.

In compulsory health insurance, too, cost looms as the number one consideration. Kenneth C. Crain, writing in *Hospital Management* for December, 1945, raises serious doubt that the cost can be controlled:

> The fact is, of course, that nobody has any idea what the scheme will cost, especially with the characteristic spendthrift methods of the Federal Government in control. Estimates range from three or four billions to double those enormous amounts. There is in the nature of things no limit to the amount of this tax when the Social Security system as a whole, and this part of it, in particular, if authorized, begins to show the enormous deficits which may be confidently predicted.

Newspapers also have been paying increasing attention to cost. Arthur Sears Henning, in *The Chicago Tribune* for November 20, 1945, said of the health measure:

> The measure is destined to meet with great opposition, particularly because of its enormous cost at a time when radical retrenchment of expenditures is required to avert inflation.

Asking the opinion of the people, the *Des Moines Register* conducted a poll in Iowa on the question of whether they favored enactment by Congress of a compulsory health plan. Here are the results:

Opposed	49 per cent
In favor	40 per cent
No opinion	11 per cent

The 40 per cent in favor were asked whether they would be willing to pay $1 a week on every $25 earned; 29 per cent answered yes, 10 per cent no. It appears that when cost is added to the menu, the meal looks less appetizing.

Research: Concern about the ultimate cost of social security has not been confined to comment and public opinion surveys. There is a growing interest in active research. Upon release of the President's health proposals, the New York Board of Trade stated that it plans to set up an impartial research bureau to study costs of present and proposed social security in the State of New York. Board of Trade members are said to feel that the approach to social security problems has been emotional and political and they are determined to discover what expansion of the system actually would cost individuals and industry. A realistic approach to the cost problem is certainly needed at this time. Congressional hearings on social security are to commence shortly, and it is highly desirable that cost and obligations under any compulsory program be made just as clear to the public as the benefits.

Surgeon General Parran Writes a Letter

Flames from the current controversy over compulsory health insurance rise ever higher. Surgeon General Parran of the United States Public Health Service added fuel to these flames when, on December 10 last, he said in a letter to all officers of the Service:

> The appropriate executive agencies of the government have been specifically instructed by the President to assist in carrying out his legislative program as presented to the Congress on September 6.
>
> Every officer of the Public Health Service will wish to familiarize himself with the President's message and will be guided by its provisions when making any public statement likely to be interpreted as representing the official views of the Public Health Service.

Bouncing back from this body blow, the American Medical Association replied in its *Journal* for January 12:

> Many of those addressed . . . are physicians in the private practice of medicine in the United States . . . If. however, men are to be directed in their thinking or muzzled in their speaking incident to their desire to be of service to the health of the nation, their rights as American citizens will have to prevail . . . it might have been better if General Parran had, in these final two paragraphs, said in shorter and clearer sentences exactly what he meant to convey.

Reaction to the Surgeon General's letter has not been limited to comment in medical journals. In Toledo, Ohio, Dr. Edward McCormick ,a senior surgeon in the Public Health Service there, and 13 reserve officers under him resigned their commissions. Said McCormick: (*Chicago Tribune,* January 18)

> We quit because we are American citizens and are sick and tired of being regimented by Presidential edict. Parran has indicated he is for socialized medicine and we are not going to be coerced by him or any other bureaucrat into supporting such measures.

Pitfalls in Compulsory Health Insurance

Experience With Socialized Medicine in Europe Shows It Has Led to Inferior Service and to Economic and Political Problems

Many European workers have found that the so-called advantages of compulsory health insurance are outweighed by very real disadvantages. For instance, if their doctor is not in the insurance practice, they have to forego the right to call him and have to accept treatment from another practitioner who is oftimes so busy that he cannot give adequate service. The drawbacks also include a deterioration of medical care in many places, an ever-increasing cost of the system due in large part to malingering and the growth of many of the administrative societies into politically powerful organizations.

In every country there has been a constant increase in the sickness rate after the introduction of health insurance. In Germany it trebled from 1885 to 1930. In England the number of claims increased by almost 50 per cent in a six-year period from 1921 to 1927. In both countries doubtless some of the increase was due to malingering, but an appreciable part was caused by poor medical service.

* * *

For instance, in Germany Dr. Frederick Hoffman found that "treatment of serious afflictions is often grossly inadequate for purposes of a cure." Often the doctors were not to blame. On the one hand, the administrative authorities stood ready to debar them from insurance practice, in case they "over-doctored," that is, saw their patients too often, for in Germany doctors are paid on a fee-for-service basis. On the other hand, physicians were overworked. Many patients thronged to their offices just to get their money's worth. Indeed, one group of physicians estimated that two-thirds of their time was consumed by such demands.

* * *

Again, in England there has been much argument about the quality of medical care given the workers. Some of the proponents of the system have insisted that they got better attention than they did in preinsurance days. Others disagree. Earnest Bevin has characterized the medical service given the industrial classes as "a tragedy of incompetence." J. G. Crownhart reported to the Wisconsin Medical Society that the English system had reduced many practitioners to the status of agents, making out prescriptions "too often for mere palliatives." He added that they operated something more like "a sickness licensing and registration system than a health service." Sir Kingsley Wood, quondam Minister of Health, confirmed Mr. Crownhart's diagnosis, when he said that the National Health Insurance System had made the English into "a nation of medicine drinkers." One authority says that the services have developed with patches of brilliance and patches of tragic incompetence.

* * *

Here, too, the doctors are not wholly responsible. Their waiting rooms are crowded. Many of them have to see anywhere from 30 to 60 patients a day. In the United States a busy doctor sees between 20 and 25 a day. Furthermore, the Ministry of Health got the druggists to make out a list of cheap drugs. The Insurance Committees which administer the medical benefits have tried to force the doctors to use the list instead of prescribing more expensive medicines. It is small wonder that under such circumstances in 1936 at least 600,000 workers failed to register so they could be eligible to see an insurance physician even though they had paid their health insurance taxes.

* * *

In addition to providing a certain amount of medical service, practically all the health insurance laws require that sick workers should be paid cash benefits which, at least partially, indemnify them for wages lost during sickness. In both England and in many continental countries these cash benefits have been administered by semi-private societies or funds. At the inauguration of the health insurance system these organizations were weak and, in England, in financial difficulties. Their history has been one of aggressive competition for power. In order to attract members they have continually liberalized the benefits they offered. For instance, many made cash payments which are considerably larger than those required by law and also gave "extra benefits," such as service at a dental clinic and care in sanitoria.

These generous benefits and the ever higher morbidity rates have resulted in a decided increase in the per capita costs. In Germany it was eight times as high in 1929 as it was in 1885. In England it doubled. This of course necessitated an increase in the contribution rate or a curtailment of benefits. Most countries have used both methods, but in Germany prior to 1929 the increase in the contribution rate was so large that labor unions were apprehensive lest workers would be unable to pay their union dues. Of course the worker's payment only increased from about 1 per cent of the wage to something over 4 per cent.

* * *

Taken alone, this increase would be rather unimportant, but the German worker has been required to pay other social security and additional taxes. Indeed, the total amount deducted often amounted to 30 per cent of the wage. That is why workers who were members of funds which paid a tax-free wage-loss benefit equal to three fourths of the wage found that it was more lucrative for them to be "sick" and claim the benefit than to work for full wages.

* * *

The same thing could happen in the United States. Actuaries estimate that the total annual cost of social security may vary between 12 and 18 billion dollars. In addition to that, the federal, state, and municipal governments must be supported. Statisticians have estimated that the annual cost to the Federal Government alone will be about 25 billion dollars. All these expenses add up to a sum equivalent to an appreciable part of America's largest prewar national income. Since the nation cannot continue indefinitely on a basis of deficit financing, someone must pay. The important question is, "Who will it be?" The source of all of our wealth is the productiveness of natural resources and the industrial system. At the hub of this stands the American worker. It is he who will ultimately pay, either directly or indirectly.

* * *

The third and most insidious danger is the political one. Investigating doctors found much evidence about the quality of medical care. The increasing cost of the systems is a matter of record, but the growth in the political importance of the administrative organization has gone almost unnoticed in most countries until a crisis. Such an emergency occurred in Germany in 1933. One of the first things the Nazis did after they took over the reins of the government was to seize control of the health insurance funds and to convert the offices into governmental agencies to aid in regimenting the people.

* * *

However, many workers suffer because of the unexpected financial drain incident to serious illness. How can this problem be solved? Through voluntary insurance. Under such a system ,there would be no disruption of medical practice through lay interference. Doctors could deal more effectively with malingerers. The economic burden of such a system would bear less heavily on the workers, as arrangements for it could be made at a time when a rise in wages was feasible. Finally, such a method could not create a political Frankenstein which might enslave us all.

LOS ANGELES

(Continued from Page 198)

ever, little difference was noted at "El Pueblo de Los Angeles" where Mexican authority followed, when Spanish domination ended. It was really only a change in name.

The beginning of the American period cannot properly be traced to a single date or incident. The Treaty of Cahuenga, the signing of which took place at Cahuenga Pass, near Hollywood, between Andres Pico and John C. Fremont, January 13, 1847, ended hostilities in California and made clear the claims of the United States which were settled at Hidalgo, Mexico, the following year. The events leading to these treaties are of great importance in early Los Angeles history.

But this garrison of fifty soldiers left at Los Angeles was insufficient to insure what otherwise might have been a bloodless conquest of the region.

Then, from out of the desert, came a new figure of importance, General Stephen W. Kearny, marching with his victorious army from the Texan campaign. At the border he had been met by Kit Carson with news of earlier victories in California. Because of this good news, Kearny sent back to the "States" all but 121 of his men. Luckily, however, with the aid of reënforcements sent by Stockton, Kearny with his remaining force reached San Diego where plans were made to march on Los Angeles—the last Mexican stronghold in California.

Marching across the hot barren desert, his weary-worn soldiers little expected the surprise attack from the elated Angelenos at San Pasqual, where thirty-seven Americans were killed and wounded in a bloody battle.

A long tedious march to Los Angeles concluded the campaign; little resistance being made by the Californians. In January, 1847, Kearny entered the city after a skirmish at La Mesa, where hardly a shot was fired.

To physicians, General Kearny's expedition which started from Santa Fe, New Mexico, on September 25, 1846, is of special interest, since the Army Surgeon who was at the head of the medical department of General Kearny's "Army of the West" was John Strother Griffin, M.D., one of the founders of the Los Angeles County Medical Association, and its first president, through election on January 31, 1871.

Later in January, Fremont entered Los Angeles from the north after having signed the treaty of Cahuenga which brought the city under a new government, the United States of America.

During all of this period Los Angeles was a very small town, with unpaved streets and no means of communication other than the stagecoach and pony express rider. In 1860 the first telegraph line came to the city. In 1868 the first bank was opened. In 1869 San Pedro and the harbor-to-be, were connected to the city by rail.

It had taken Los Angeles ninety years to gain the 5,000 population it had in 1870. From this date growth was much more rapid. The first railway had caused the population to double by 1880. During the next ten years the population jumped 350 per cent so that, by 1890, there were 50,000 in Los Angeles; many of them had taken advantage of the railway rate wars which made it possible for immigrants to come from the Middle West to Los Angeles for fares as low as one dollar. By 1900 the population had again doubled to more than 100,000.

A census estimate of January, 1946, credited Los Angeles County with 2,785,643 in 1940 and 3,584,000 in January, 1946, (CALIFORNIA AND WESTERN MEDICINE, February, 1946, p. 111).

The first influx of Easterners to the local area was supported solely by booms in real estate, but as rail rates returned to normal, the tide of inflowing population ebbed and banks became stricter in their loaning policies. The tourist trade dropped off and a general depression set in. This was in 1888, the same year in which the Los Angeles Chamber of Commerce was founded. At this time the residents began to realize that they must produce if their progress was to continue.

In 1885 California citrus fruit won over Florida fruit for the first time at the International Exposition at New Orleans.

With increased agricultural production, trade was begun. Domestic trade had been carried on spasmodically for a considerable time, but it was not until 1899, when the first actual work began on a deep-water harbor, that the city undertook an extensive foreign trade program.

During 1899 and 1900 a boom in oil began and carried on to such an extent that today the production of crude oil and its refining is the leading industry. Los Angeles' second industry—motion pictures—got its start in 1910 when the Nester Film Company came to Hollywood.

Industrially, Los Angeles has grown until, by 1938, it became the fifth among United States counties. In more recent years this area has come to produce more airplanes than any other section of the United States. It is a leader in automobile and accessory production, in tires, furniture, wearing apparel, printing and publishing, and meat packing.

Los Angeles has an approximate population of 1,350,000. The city's area is 450.74 square miles, one of the largest cities in area in the world—the largest in the United States. Culturally, Los Angeles is growing as rapidly as it is industrially. Science, art, music and literature are encouraged.

Phi Rho Sigma Luncheon

Clark Hotel, 426 South Hill Street, Michigan 4121. Wednesday, May 8, 1946. For information, address J. M. de los Reyes, 424 California Medical Building, 1401 South Hope Street (Telephone PRospect 8146).

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings[†]

California Medical Association. Session will convene in Los Angeles. Headquarters, Hotel Biltmore, 5th and Olive Sts. Dates of meetings: Tuesday, May 7-Friday, May 10, 1946.

American Medical Association. The next annual session of the American Medical Association will be held in San Francisco, July 1-5, 1946. (Monday-Friday, inclusive.)

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in CALIFORNIA AND WESTERN MEDICINE for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576. Also, August, 1945, CALIFORNIA AND WESTERN MEDICINE, pp. 61-62.) On p. 61 (C.M.A.) and p. 62 (A.M.A.)

Medical Broadcasts[*]

The Los Angeles County Medical Association:

In April KFAC will present broadcasts on Saturdays at 10:15 a.m.; April 6, 13, 20, and 27.

The Saturday broadcasts of KFI are given at 9:45 a.m., under this title, "The Road to Health."

"Doctors at War":

For radio broadcasts of "Doctors at War" by the American Medical Association, see *J.A.M.A.*

Pharmacological Items of Potential Interest to Clinicians[*]:

1. *Symposia and Reviews:* M. Shimkin opens important symposium on breast cancer with full review of experimental induction (*Surgery,* 19:1-154, 1946). Note helpful symposium on sciatica, low back pain, and intervertebral disk disease by N. Little & Co. (*Med. J. Austral.,* 1:33-52, Jan. 12, 1946). E. H. Reinhard & Co. offer comprehensive review of radiactive phosphorus as therapeutic agent (*J. Lab. Clin. Med.,* 31:107, 1946). W. Sheldon well reviews tuberculous rheumatism and H. S. Barber discusses difficulties in diagnosing rheumatic fever (*Lancet,* 119, 122, Jan. 26, 1946). Note E. W. Dempsey and G. B. Wislocki's survey of histochemistry, D. E. Gregg on coronary circulation, J. Furth on leukemia, G. H. Bishop on cutaneous sense mechanisms, A. C. Frazer on absorption of fat, J. M. Buchanan and A. B. Hastings on metabolism studies with isotope carbon, and A. P. Heusner on yawning (*Physiol. Rev.,* 26:1, 28, 47, 77, 103, 120, 156, 1946). Watch for accumulated exuberance from March meetings Federation of American Societies for Experimental Biology (*Fed. Proc.,* 5:1, 1946). F. W. Bancroft and C. Pilcher edit *Surgical Treatment of the Nervous System* (Lippincott, Phila., 534 pp., 1946, $18). J. F. Fulton edits 15th ed. Howell's *Textbook of Physiology* and it's up to the minute (Saunders, Phila., 1946, 1304 pp., $8). F. Hawking and F. H. K. Green edit *The Medical Use of Sulphonamides* (Med. Res. Counc. War Memo. 10, 2nd ed, London, 1946, 71 pp., 1s 3d). B. Blanshard, C. J. Ducasse, C. W. Hendel, W. E. Murphy, and M. C. Otto survey *Philosophy in American Education* rather sourly (Harper, N. Y., 1946, 306 pp., $3). And there is still more on ethicogenesis (*Sci. Month.,* 62:185, 1946).

2. *Philosophical:* Have you seen W. A. Sinclair's little but stimulating *Introduction to Philosophy* (Oxford Press, N. Y., 151 p., $1.50)? L. Mumford's *The Condition of Man* is tough, tense and turgid (*Harcourt Brace,* N. Y., 467 p., $5). K. Burke's *Grammar of Motives* is semantic introduction to trilogy on human relations (Prentice-Hall, N. Y., 530 pp., $5). M. R. Cohen essays keenly *The Faith of a Liberal* (Holt, N. Y., 497 pp., $3.75). A. E. Cohn's *Minerva's Progress* emphasizes importance of dissent in tradition (Harcourt Brace, N. Y., 101 pp., $2). A. E. Clark-Kennedy discusses *Art of Medicine in Relation to Progress of Thought* (Cambridge Press, 2s, 1946).

3. *Physiological:* B. H. Crawford discusses photochemical principles in explanation of recovery phenomena in visual sensitivity (Proc. Roy Soc., B:133:63, 1946). A. Szent-Gyorgi discusses contraction in relation to chemical structure of muscle fibril (*J. Colloid Chem.,* 1:1, 1946). T. H. Bullock & Co. report on reversible effects of inhibitors of choline esterase on nerve action potentials (*J. Neurophysiol.,* 9:9, 1946). Our E. Ogden pleasantly teleologizes on respiratory flow in the dogfish (*Am. J. Physiol.,* 145:134, 1945). Our H. J. Ralston, W. O. Collings, A. N. Taylor and E. Ogden find tissue

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[†] In the front advertising section of ***The Journal of the American Medical Association,*** various rosters of national officers and organizations appear each week, each list being printed about every fourth week. In CALIFORNIA AND WESTERN MEDICINE, some rosters appear in every second or third issue.

[*] County societies giving medical broadcasts are requested to send information as soon as arranged.

[*] These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

elasticity helps return venous blood in absence of cardiac drive (*Am. J. Physiol.*, 145:441, 1946).

4. *Pharmacological:* F. W. Schueler offers neat biochemorphic theory for sex hormonal action (*Science*, 103:220, Feb. 22, 1946). E. R. Loew & Co. find powerful anti-histamine action in triazine ethers (*J. Pharmacol. Exp. Therap.*, 86:7, 1946). N. K. Schaffer and T. A. Loomis report on pyrrolidine dicarboxylic acid local anesthetics (*Yale J. Biol. Med.*, 18:157, 171, 1946). C. H. Andrews & Co. describe anti-rickettsail action of p-sulfonamido-benzamidine in stimulating discussion of experimental chemotherapy of typhus (*Proc. Roy Soc.*, B: 133: 20, 62, 1946). R. C. Gill clarifies ideas on development of curare (*Anesth.*, 7:14, 1946). Watch for modified amino heptanes as vasopressors: Lilly has 2-amino heptane, now comes Bilhuber with 2-methylamino heptane (*Ibid.*, p. 62). K. Meier recommends sulfadimethylpyrimidin as best sulfa for children because of least effect on kidney (*Schweiz. Med. Woch.*, 75:1097, Dec. 15, 1945).

5. *Odds and Endsical:* F. C. Courtice recommends local cooling to reduce fluid loss in thermal burns (*J. Physiol.*, 104:321, 1946). T. Teorell proposes quantitative theory for antigen-antibody reactions (*J. Hyg.*, 44:227, 237, 1946). G. E. Burch discusses water and heat loss from lungs in tropics (*Arch. Int. Med.*, 76:308, 315, 1945). G. Duboff & Co. demonstrate enzyme inhibitor in serum from cancer patients (*Cancer Res.*, 6:57, 1946). G. H. Twombly and D. Meisel fail to confirm A. Taylor & Co.'s idea (*Science*, 97:123, 1943) of a filterable cancer virus (*Ibid.*, p. 82).

"A" Bomb Health Man Returns to U. C.—Dr. Robert S. Stone, professor of radiology in the University of California Medical School, has returned to his position after nearly three years at the University of Chicago, where he was in charge of the health aspects of that institution's atomic bomb project.

Dr. Stone has done much work on the effects of artificial radioactivity on human and animal tissue, and led the Medical School's research prior to the war in biological research connected with the cyclotron.

Dr. Stone was recently appointed to the National Advisory Cancer Council. He is still a consultant to the Manhattan Project, the Army organization which administered the atomic bomb research.

Grant From Baruch Committee on Physical Medicine to U. S. C.—The University of Southern California has received a grant of $30,000 from the Baruch Committee on Physical Medicine. It is one of 11 schools sharing in the original grant of $1,100,000 made by Bernard M. Baruch in 1944 to the Baruch Committee on Physical Medicine. The purpose of these grants is to advance and encourage research, teaching, and training in the field of physical medicine, and to bring the benefits of this branch of medicine to the rehabilitation of persons maimed in war, industry, or by illness.

Under the direction of Dr. Irving Rehman at the University of Southern California, research planned or in progress includes: The evaluation of compensatory action of muscles or muscle groups; the use of soft tissue x-rays and metal pin implants to study muscle movement; the determination of electrical potentials in muscle contractions; the interruption of neuromuscular pathways by pressure, nerve section and chemicals; the effect of internal environment on regeneration of neuromuscular pathways and return of function.

Alum Rock Sanatorium Receives $5,000 for Medical Research.—It was announced by Dr. Harold Guyon Trimble, Chairman of the Board of Trustees of Alum Rock Sanatorium of San Jose, that a gift of $5,000 was received for medical research.

Alum Rock Sanatorium, San Jose, California, is a nonprofit institution for the treatment of diseases of the chest.

This gift will establish the Philip H. Pierson Memorial Medical Research Fund as a dedication to his unselfish devotion and scientific attainments in the field of medicine, particularly diseases of the chest. Dr. Pierson, Clinical Professor of Medicine at Stanford University Medical School and consultant at Alum Rock Sanatorium, died unexpectedly on January 17, 1946.

U. S. Public Health Service Announces Openings.—Appointments to fill vacancies in the Reserve Corps of the U. S. Public Health Service are now being made, and examinations for Regular Corps appointments will be held in April and May. Physicians, dentists, and nurses are needed immediately for duty in hospitals, in the Tuberculosis and Venereal Disease Control Programs, and in other activities of the Public Health Service.

Persons interested in immediate appointment in the Reserve Corps or in taking the examination for the Regular Corps, should request application forms of the Surgeon General, U. S. Public Health Service, Federal Security Agency, Washington, D. C.; or of the Medical Director, U. S. P. H. S. District No. 5, 630 Sansome Street, San Francisco.

Oral examinations for Regular Corps appointments for medical officers will be held April 9th in Los Angeles; April 10th, 11th in San Francisco. Written examinations will be held May 14th, 15th, and 16th.

Rôle of Pharmacy in a National Health Insurance Plan.—Pharmacists should begin to determine what will be the rôle of pharmacy in event the President's national health insurance program is adopted or the alternative plan of the American Medical Association, it is advised by the District of Columbia Pharmaceutical Association.

"Maybe we don't know what we want," the association publication declares, "but at least we should begin to undertake to determine what is to be the place pharmacy will occupy in each program and prepare ourselves to fit the niche carved out for us."

Borden Award Given U. C. Medical Student.—Dr. Robert Oliver Scow, *Avenal*, has been presented the annual Borden undergraduate research award of $500 by unanimous choice of the research committee of the University of California Medical School.

The award, financed by the Borden Foundation, is made annually to a graduating senior for research which is deemed most meritorious. Dr. Scow has led or participated in research which has resulted in the publication of 10 scientific papers. The research committee commended Scow for marked ingenuity in research.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Program for School Health Institutes

The program is announced for the School Health Institutes to be held in March and April under the joint sponsorship of the California State Department of Public Health and Education. Following is the schedule of meetings:

Oakland, March 18, 19, 20, Board of Education Auditorium, East 10th St. and 2nd Ave.

Sacramento, March 21, 22, 23, City Council Chambers, City Hall.

Fresno, March 25, 26, 27, Fresno State College.

Santa Barbara, March 28, 29, 30, Recreation Center, 914 Santa Barbara Street.

San Diego, April 1, 2, 3, County Schools Service Building, 1253 University Ave.

San Bernardino, April 4, 5, 6, Calvary Baptist Church, 19th and E Streets.

Program participants will include the following: Dorothy B. Nyswander, Ph.D., Health Education Specialist, Inter-American Educational Foundation, Inc.; Alberta Wilson, P. H. N. Assistant Director, National Organization for Public Health Nursing; Dr. L. C. N. Wayland, Director of Health, Santa Barbara City Schools; Dr. G. G. Wetherill, Director of Health Education, San Diego City Schools; Dr. Jessie M. Bierman, Chief, Bureau of Maternal and Child Health, State Department of Public Health: Verne S. Landreth, Chief, Division of Recreation, State Department of Education; Dr. Dorothy Lottridge, Maternal and Child Health Officer, State Department of Public Health; Bernice Moss, Consultant in School Health Education, State Department of Public Health; Cecyl Nelson, Supervisor, Community Health Education Project, State Department of Education: W. H. Orion, Chief, Division of Physical and Health Education, State Department of Education.

Bills for Better Care for Children and Aged

Examiner Bureau, Sacramento, March 8.—Governor Warren today signed two legislative bills intended to assure maintenance of adequate standards in California homes for children and aged persons.

The measures permit the State department of social welfare to contract with city or county governments for inspection of licensed homes in cases where the local service meets State department standards. The State will pay the local government $3 per license per month for performing the service. The bills appropriate a total of $441,000 for this purpose.

The Governor signed another bill increasing from 1½ to 2½ mills the permissible tax rate which counties with less than $50,000,000 assessed valuation may levy to raise money for veterans' memorial halls. — San Francisco *Examiner*, March 9.

Penicillin Lozenges for Trench Mouth

New York, March 6.—(AP.)—The United States Naval Medical Bulletin announces a new use of penicillin, to cure trench mouth, and to cure it quickly. In 400 cases tried there has not been one failure.

The penicillin is given like candy, in lozenges, which are allowed to dissolve in the mouth. The trench mouth victim keeps a lozenge, one after another, in his mouth all day and takes one if he wakes up at night.—San Francisco *Examiner*, March 7.

California 1945 Per Capita Income Less Than 1944

Sacramento, Feb. 24.—(UP.)—California's civilian per capita income of $1,415 for 1945 remained well above the national average but below the 1944 State figure, the California State Chamber of Commerce announced today.

The total civilian income for State residents was $11,492,100,000. The national per capita figure was listed by the chamber as $1,117.

While California's 1945 per capita income was below the $1,540 figure for 1944, it remained well above the 1939 income of $737.—Los Angeles *Times*, February 25.

Geriatrics

Official Journal of the American Geriatrics Society
A Modern Medicine Publication

A new medical journal *Geriatrics* recently appeared. It has taken the name coined in 1908 by Dr. Leo Nascher, who wrote a text book entitled *Physiological Changes in Old Age*. Geriatrics derives from two Greek words: *geras*, meaning old age, and *iatrikos*, relating to the physician. There are few doctors who are exclusively Geriatricians but every general practitioner is called upon more and more to practice Geriatrics, for there is an ever increasing number of old people.

This is literally the age of Age. More than 26,000,000 persons in the United States, or 20 per cent of our population, are 45 years of age and over. Admittedly this greater span of human life in recent decades is attributable to progress in child care. Now the trend is developing toward giving the older person the same seduious medical care which the younger person has had.

The first State Board of Health to develop a Division of Geratology is that of Indiana. Its express purpose, so the board states, is a study of the factors affecting advancing age and the application of knowledge now available concerning the diseases and disabilities of age, not only that the years of life may be increased in number but also that increased happiness and usefulness may be added to these years.—*Press Release.*

Manuscripts Invited for Norton Medical Award

The book publishing firm of W. W. Norton & Company announce that they are again inviting manuscripts for submission to be considered for the Norton Medical Award of $3,500 offered to encourage the writing of books on medicine and the medical profession for the layman. The first such award was made to *The Doctor's Job*, Dr. Carl Binger's book, published last spring, which gave the doctor's point of view on his work. Announcement will be made shortly of the winning book for 1946. Closing date for submission of manuscripts this year is November 1, 1946. All particulars relating to requirements and terms may be had by addressing W. W. Norton & Company, Inc., 70 Fifth Avenue, New York 11, N. Y.—*Press Release.*

MEDICAL JURISPRUDENCE†

Hartley F. Peart, Esq.
San Francisco

Privileged Communications Between Physician and Patient in California

The relationship which springs into existance when a patient consults a physician for treatment often gives rise to a large number of perplexing legal and ethical questions. This article will not concern itself with any of the ethical aspects pertaining to the keeping inviolate of information coming into the hands of a physician from a patient, but will confine itself to the legal aspects thereof. One of the most important of legal problems which may confront a physician in his relations with a patient are the rights, obligations and duties of the physician in connection with the disclosures and communications which a patient will make to him.

In an effort to cover the field of the so-called physician-patient privileged communications rule, this discussion will treat not only with civil matters but also will concern itself with criminal actions, criminal investigations and other proceedings, including autopsies, wherein the contention is made by a patient that communications which the patient made to the physician were of a confidential nature and therefore the physician was precluded from divulging them. Hence this article will be divided into: first, civil actions wherein the physician-patient privilege communications rule is invoked; and, second, criminal actions wherein the rule is invoked. In turn, the second division will be subdivided into, first, criminal actions proper; and second, criminal investigations.

I. Privileged Communications Between Physician and Patient in Civil Actions

At common law a physician, when called upon to testify as a witness, had no right to decline or refuse to disclose any information, on the ground that it had been communicated to him confidentially in the course of his treatment of a patient in a professional capacity. No such privilege extended to communications between a physician and patient as that which protected the confidences between an attorney and his client. Thus, in the English case of *Rex vs. Gibbons*, decided in 1823, a physician was called as a witness in an action involving an illegitimate child. The physician refused to testify, basing his refusal on the reason that his knowledge had been obtained in confidence while treating the defendant in his professional capacity as a surgeon. The high court of England held that this was not a sufficient reason to prevent a disclosure for purposes of justice.

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† Editor's Note.—The department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

Statutes have now been enacted in approximately one-half of the states changing the common law rule and making communications between a psysician and patient privileged, under certain circumstances, from compulsory disclosure. The purpose and theory behind such statutes is that the privilege is necessary to protect a person in need of medical aid against the disclosure and consequent publicity of his bodily ailments; to safeguard him against the humiliation and annoyance which would often follow the disclosure of those matters which are revealed to physicians only to enable them to exercise the humanitarian capabilities of their profession. It is stated in the early California case of *McRae vs. Erickson* (1905), 1 Cal. App. 326, that the reason for the privilege is to lend a sense of security and confidence to the relationship so that a patient will not be reticent about making disclosures which may be material to his physical welfare. The California statute pertaining to this privilege is set forth in Subdivision 4, Section 1881 of the *California Code of Civil Procedure* and is as follows:

> "There are particular relations in which it is the policy of the law to encourage confidence and to preserve it inviolate; therefore, a person cannot be examined as a witness in the following cases:
>
> A licensed physician or surgeon cannot, without the consent of his patient, be examined in a civil action as to any information acquired in attending the patient, which was necessary to enable him to prescribe or act for the patient; . . ."

So it can be seen that, in general, California law requires that there be a confidential relationship between a physician and his patient and that unless the facts come within one of the exceptions to this general rule, a physician cannot be compelled to disclose any information acquired by him in prescribing or acting for the patient.

Privilege is that of the Patient.—Under the California law the privilege is entirely that of the patient for it is clearly expressed in the statute and is supported by a multitude of cases that a physician or a surgeon cannot be examined "without the consent of the patient." Thus the physician is immediately confronted with the question of what constitutes consent on the part of the patient, to a disclosure of information which he has made to his physician. Shedding some light on this question, the California courts have held that the consent of the patient can be either express or implied and that once the privilege has been waived, such waiver is final and cannot be recalled. The basis for such ruling being that the object of a statute granting the privilege to a patient is not absolutely to disqualify a physician or make him an incompetent witness, but to enable the patient to secure medical aid without betrayal of confidence. Since the privilege is therefore for the patient's protection, he may waive it if he sees fit and this he may do either by express or implied consent or by calling the physician to testify as to the communication made.

What constitutes waiver by a patient? Since it is possible for the patient to waive this privilege which the rule affords him, it becomes important to determine just what acts by a patient will be sufficient to constitute such a waiver and thereafter make it permissable for a physician to freely disclose all information which he acquired from the patient. A waiver by the patient will be effected if third persons unnecessary and unessential to the treatment are present while the physician is prescribing for or treating the patient. For example, in *Horowitz vs. Sacks*, 89 Cal. App. 336, it was held that where a husband, brother and mother of the patient were all present at the time of the examination, the communications made were not confidential. In *Kramer vs. Policy Holders Life Insurance* (1935) 5 C.A. (2nd) 380, the court held that the presence of a nurse or of a nurse-stenographer during the physical examination did not operate as a waiver of the privilege by the patient because "the communications were made in the presence of a necessary third party who was acting as the agent of the doctor under his direction and supervision and under such circumstances that the patient had every right to conclude that the presence of such third party was necessary."

The patient may contract to waive his privilege but such a contract will be construed in favor of the patient. Thus in *Turner vs. Redwood Mutual Life Ass'n.* (1936) 13 C.A. (2nd) 573, where an action was brought against a mutual life association to recover on a policy of life insurance where the application for insurance, after describing certain past ailments and giving the names of the two physicians, contained the following authorization. "I hereby authorize any doctor at any time to give to said association any information he or she may have regarding me." It was held by the California Appellate Court that this agreement did not constitute a waiver of the patient's privilege as to the testimony of physicians treating the patient after the date of the policy.

In spite of decisions in this and other states holding that in a number of situations the physician-patient privilege has been waived by the patient, the only safe course for a physician to follow is to insist that the patient give an express consent in writing before any knowledge or information acquired by the physician is disclosed.

(To be continued)

MEDICAL EPONYM

Schilder's Disease

This eponym refers to a form of encephalitis first described by Dr. Paul Schilder (b. 1886), while a teaching assistant of the Royal Psychiatric Clinic in Leipzig, in a paper entitled "Zur Kenntnis der sogenannten diffusen Sklerose: Über Encephalitis periaxialis diffusa [Contribution to the Study of So-called Diffuse Sclerosis: Encephalitis periaxialis difusa]," which was published in the *Zeitschrift für die gesamte Neurologie und Psychiatrie* (10:1-60, 1912). A portion of the translation follows:

"There is a diffuse affection of the white substance of the hemispheres in children that we are justified in regarding as a disease entity on the basis of characteristic macroscopic and microscopic findings in the brain. I propose for it the designation "encephalitis periaxialis diffusa."

"The clinical picture of this disease is extremely variable. It follows a course which sometimes resembles that of brain tumor, sometimes simulates multiple sclerosis, or again resembles Heubner's diffuse sclerosis. We may suspect the existence of this disease if symptoms point compellingly to a widespread lesion involving both hemispheres. Attacks with the symptomatology of multiple sclerosis running a rapid course in youthful patients will likewise bring our disease to mind. The disease is a fatal one, with little tendency to remissions."—R. W B. in *New England Journol of Medicine.*

'Tis our true policy to steer clear of permanent alliances, with any portion of the foreign world.
—Washington, *Farewell Address,* 17 September, 1796.

All that a man hath will he give for his life.
—*Old Testament: Job,* ii. 4.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIX, No. 4, April, 1921

EXCERPTS FROM EDITORIAL NOTES

A New Secretary.—The office of Secretary of the Medical Society of the State of California [California Medical Association] is one of considerable importance, for, while the secretary is not the dictator of the policies of that organization, he is to a great extent guardian of its character and director of its destinies. The Council, of course, is the great executive center, and the House of Delegates is its legislative body.

The re-organization of the State Medical Society under the initiative of the late Dr. Philip Mills Jones marked an epoch in its life, and the work of Dr. Jones was of paramount importance. He was a man of striking qualities and to him we can look as the patron saint of our Society. . . .

At his death Dr. Saxton Pope was elected secretary and during his term of office the State Society has prospered. Its finances have been put on a firm basis, its membership increased, and the work of Dr. Jones, as outlined by him, has been carried forward. The Indemnity Defense Fund, which was one of his later developments, has assumed very healthy proportions; medico-legal defense has been conducted with unfailing success; the STATE JOURNAL is the best in America. . . .

All Aboard for San Diego.—Why not give yourself and your family a treat next month and go to San Diego May 10, 11 and 12, 1921 for the State Meeting? . . .

Incidentally, remember once more that you are the owner and manager of the California State Medical Society. It does what you permit it to do. If its tricks are not to your taste, just step in and have them changed. It will do what you tell it to do. A live medical profession is a blessing to the entire community. Make yours a blessing. It will give back to you all you give to it and more. Come to San Diego. Remember you are a member, recall that you can give something worthwhile by your presence; be assured you will get rich repayment; do not forget the extra curriculum activities. Come.

Radiology is a Medical Specialty.—Medical radiology today embraces a vastly wider field than the delineation of a fractured bone. It is well for the average doctor to realize that successful diagnosis now demands a nearly constant employment of the x-ray. Probably no field of medical or surgical work has been exempt from the diagnostic or the therapeutic advantages of radiology. Certainly no physician can pretend to practice in general or in a specialty in this age without constant reference to data secured by the x-ray and its frequent use in treatment. . . .

The possession of a stethoscope and a hypodermic does not make a doctor. Neither does the possession of an x-ray plant make a radiologist. You should consider this matter with the closest scrutiny and decide whether you

(Continued in Back Advertising Section, on Page 42)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.
Secretary-Treasurer

Board Proceedings

The Board of Medical Examiners met in Los Angeles on March 9th and 10th, at which time oral examinations were given. There were about 100 applicants who had been certified for this examination. Written examinations and hearings were conducted by the Board at the meeting in Los Angeles on March 11th to 14th. About 225 applicants had signified their intention to appear for the written examination.

The majority of applications for reciprocity being received at the present time are from medical officers in one of the branches of our armed forces, or from those who have been recently discharged. These applicants are from practically every state in the United States.

The hearings now being held before the Board come under the provisions of the Administrative Procedure Act, which was added to the Government Code under Chapter 867 of the Statutes of 1945. Under this new procedure, the State is divided into three districts and hearings can only be heard in the district in which the transaction or violation occurs, or in the district in which the resident resides.

News

"Doctor Indicted In Abortion—Oroville—Dr. Walter C. Hoyt, 64, was indicted by the County Grand Jury on charges of abortion. The district attorney's office said that his arraignment will probably take place in Superior Court February 25. . . . In the absence of Judge Harry Dierup, Superior Judge Warren Steel of Yuba County, presided at the trial. . . . District Attorney McPherson said the case of John Vigna, 68, charged with assault with a deadly weapon, will be reviewed at a later date." (*Sacramento Union*, February 17, 1946.)

"Anderson Quits Medical Board Job—Resignation of Walter N. Anderson, chief special agent for the State Board of Medical Examiners, to enter private law practice was announced yesterday. . . . Anderson's post will be taken by Maynard C. Youngs, who has been associated with the State several years." (Los Angeles, Calif. *Examiner*, February 12, 1946.)

"Medical Veterans Form Association—Beginning what they hope will become a national organization, 400 doctors last night met at the Los Angeles County Medical Building and formed the Medical Veterans' Association with Dr. William Leake of Beverly Hills as president. . . Aims of the organization are to assist medical men in finding houses and offices, assuring more medical care for veterans and using their war-gained knowledge to advance medical practice. . . . Others elected were Drs. Wells Cook, vice-president; Frederick Bennetts, secretary, and William Delphia, treasurer." (Los Angeles, Calif. *Times*, January 8, 1946.)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members. Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco 8.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

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By promoting normal peristalsis without irritating the delicate mucosa, Metamucil is particularly desirable for treating the constipation of hospital patients.

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SURGERY—Two Weeks Intensive Course in Surgical Technique starting May 6, May 20, and every two weeks thereafter. Four Weeks Course in General Surgery starting May 6, June 3, July 15. One Week Surgery Colon and Rectum starting April 29, June 10. One Week Course Thoracic Surgery starting April 22, May 13.

GYNECOLOGY—Two Weeks Intensive Course starting May 20, June 17. One Week Personal Course in Vaginal Approach to Pelvic Surgery starting May 13, June 10.

OBSTETRICS—Two Weeks Intensive Course starting May 6 and June 3.

MEDICINE — Two Weeks Intensive Course starting May 13.

ELECTROCARDIOGRAPHY AND HEART DISEASE—Two Weeks Intensive Course starting August 5.

GASTROSCOPY AND GASTROENTEROLOGY — Two Weeks Personal Course June 3.

DERMATOLOGY AND SYPHILOLOGY—Two Weeks Course starting May 20.

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$2,900,000.00 INVESTED ASSETS **$13,000,000.00 PAID FOR CLAIMS**

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Disability need not be incurred in line of duty—benefits from the beginning day of disability.

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Penicillin is the best agent available for the treatment of this devastating disease. Although in a few instances it may be desirable to use the continuous intravenous route, intramuscular injection is the one of choice. If best results are to be obtained 200,000 to 300,000 units should be given daily for three weeks or longer. (Keefer, C. S. et al.: New Dosage Forms of Penicillin, J. A. M. A. 128:1161, Aug. 18, 1945.)

Bristol Penicillin, because of its low toxicity and freedom from pyrogens, as well as its absolute sterility and standard potency, provides dependable therapeutic action.

The rapidly developing new clinical uses of this potent antibiotic are abstracted in issues of the *BRISTOL PENICILLIN DIGEST*. If you are not receiving *your copies* regularly, drop us a line.

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THE SOUTHARD SCHOOL

For the Education and Psychiatric Treatment of Children of Average and Superior Intelligence. Boarding Home Facilities.

TOPEKA, KANSAS

BOOK REVIEWS

(Continued from Front Advertising Section, Page 28)

bilities of the day we cannot wisely solve our social and economic problems. Too much of man's estate, in an industrial age, consists in serving institutions or even machines. Our scientific and technological advances are outstripping our capacity to understand and use them. If in coming generations the clinical skill of medicine combined with the ingenuity and industry of our scientists in general could be widely applied to the study of the *science of the person*, the nation would have taken the greatest possible forward step. Comparatively few people have worked specifically in this field. Their numbers must be greatly increased, and their cause strengthened by the kind of public support now given to other great issues.

The scope of present knowledge does not cover adequately the capacities of each young person, a condition of affairs which has led inevitably to the development of undifferentiated mass educational procedures. In too many cases our general ignorance has led to prolonged trial-and-error periods before young men have been able to find their proper places in society.

Much has been written about the science of personality. Before there can be a science there must be a skill. A skill is always practical, manipulative, or clinical. Medicine, in several centuries of history, had developed great clinical skill in diagnosis and treatment before the appearance of the scientific laboratory. But in this matter of understanding and judging the person who is fit for his service to society we have at present very little skill indeed. The present study, which the volume presents, in common with several others throughout the country, represents an attempt to lay the foundations of such a skill.

(Continued on Page 42)

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BOOK REVIEWS

(Continued from Page 36)

Don't Be Afraid! How to Get Rid of Fear and Fatigue. By Edward Spencer Cowles, M.D., Director of the Park Avenue Hospital, New York; Fellow of American Association for the Advancement of Science; Fellow of the New York Academy of Sciences. Foreword by Maurice Maeterlinck. Cloth. Price, $2.00. Pp. 251. New York, Chicago: Wilcox & Follett Company, 1945.

In a foreword to this volume, Maurice Maeterlinck writes: "All forms of fear are tracked down; fear in its hundreds of different aspects, according to the observations of Dr. Cowles, is at the source of almost all mental illness, of all obsessions: claustrophobia, or fear of closed places; agoraphobia, or fear of open spaces; zoophobia, or fear of animals; sitiophobia, or fear of drinking; mysophobia, or fear of germs; fear of the future, fear of death, fear of the unknown, etc.

"All of us live in fear of something, but this fear, so long as we feel well, seems not to require notice by us. It becomes felt and disquieting only when the energy of the nerve cell is exhausted. Unbalanced and abnormal, the fear then helps to produce a series of mental illnesses and reproduces, for example, the symptoms of an illness that does not exist, although it may resemble ulcers of the stomach, appendicitis, heart trouble, etc."

Guy E. Shipler, Editor, the *Churchman*, expresses himself as follows:

"Dr. Cowles was the first psychiatrist to teach that fatigue was the basic cause of the functional nervous breakdowns; that fatigue intensifies the common sensations of the body, and that the patient interprets these common sensations in terms of danger. The method is a new one. It took the war to make the people in general realize that fatigue and fear were their greatest enemies. Up to the time of the war, everything was Freud and sex and psychoanalysis. Dr. Cowles stood steadfastly against Freud's sex theories and psychoanalysis, and with his new methods dealing with fear and fatigue delivered patients rapidly out of their mental and emotional distress back to healthy normal people."

TWENTY-FIVE YEARS AGO

(Continued from Text Page 282)

will send your patients to non-medical x-ray technicians, or whether you will insure for them the skilled services of a trained medical radiologist. Radiology is strictly a medical specialty. It requires qualities which can only be secured through the medium of a medical education. Consider well whether the best interests of your patients as well as of your own profession, are not served by keeping radiology as a strictly medical specialty and employing only qualified physicians as radiologists.

Care of Crippled Children.—At the present time, interest in better health for children occupies a greater position in the popular mind than ever before. The up-to-date physician views these child welfare movements with gratification. One of the pressing of these problems is the urgent need for better care, both medical and educational, of the crippled class of children. Among these children the mentally normal, but physically handicapped by some deformity either congenital or acquired, can be benefited by adequate medical care, thereby giving them a better chance to gain an independent state in later life. . .

The Commitment of the Insane.—It is commonly recognized that there exist serious abuses in our present method of commitment of the insane and that the method is neither economical, scientific or humane. We might go

(Continued on Page 48)

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TWENTY-FIVE YEARS AGO

(Continued from Page 42)

further with the statement that the present method is grossly out of date and based on a wrong conception of the problem involved and the result to be desired. Commitment should not be a police function nor should the mentally sick be subject to police control. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Indications for Infusion of Blood Substitutes and Transfusion of Blood in Cases of Traumatic Hemorrhage and Shock," by Edmund Butler, M.D., San Francisco.—It is not my intention in this paper to definitely outline clean cut, absolute indications for the infusion of acacia, glucose or sodium bicarbonate solutions, nor for the transfusion of blood; but it is my desire to make plain the more or less relative complex that guides us in the treatment of shock in the San Francisco Emergency Hospital Service.

Cannon defines shock as "A general body state occurring after severe injury, characterized by low arterial pressure, rapid pulse, pallor or slight cyanosis, sweating, superficial rapid respiration, and usually by a dull mental state." . . .

From an Article on Episodic Mental States and Border-Line Conditions in Psychiatry," by Charles Lewis Allen, M.D., Los Angeles.—In our consideration of supposed mental abnormalities we are at once confronted by the lack of a standard of mental normality. On account of our want of intimate knowledge of those processes which are the basis of the manifestations which we bring together under the name of mind, it seems improbable

(Continued on Page 52)

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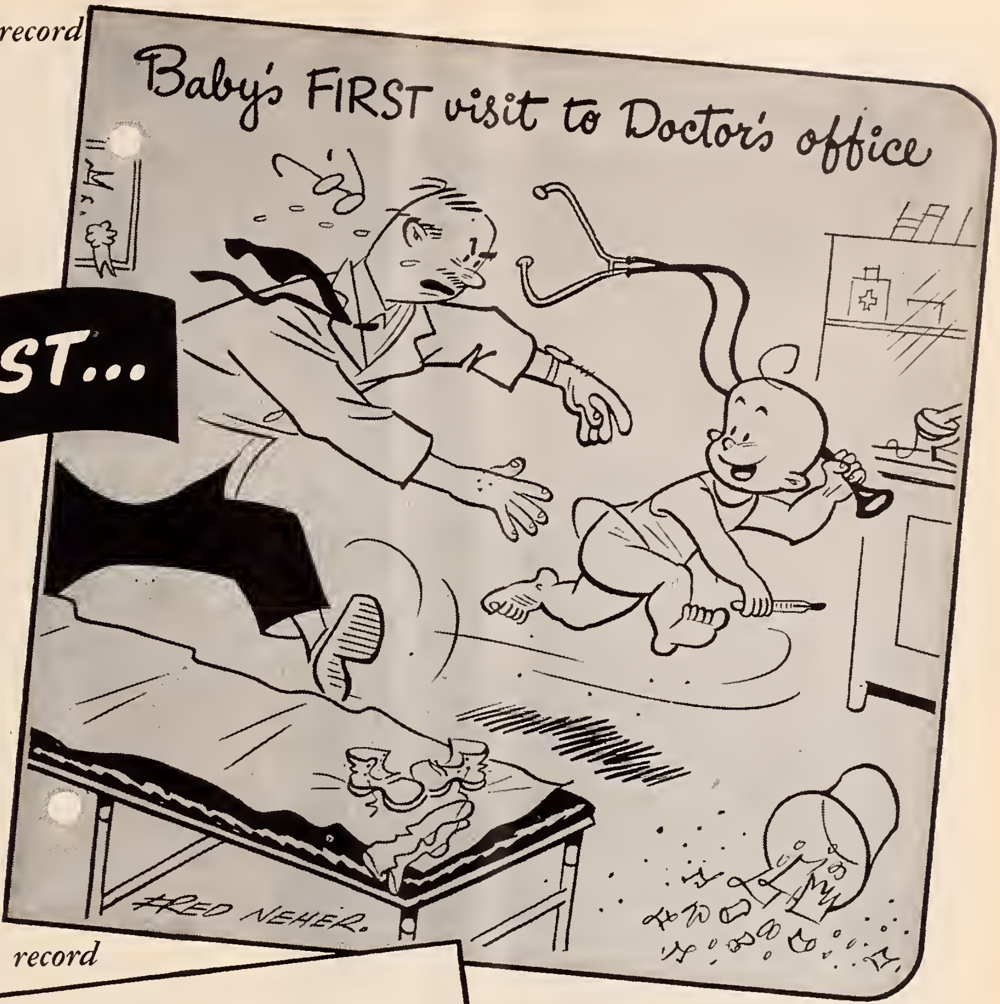
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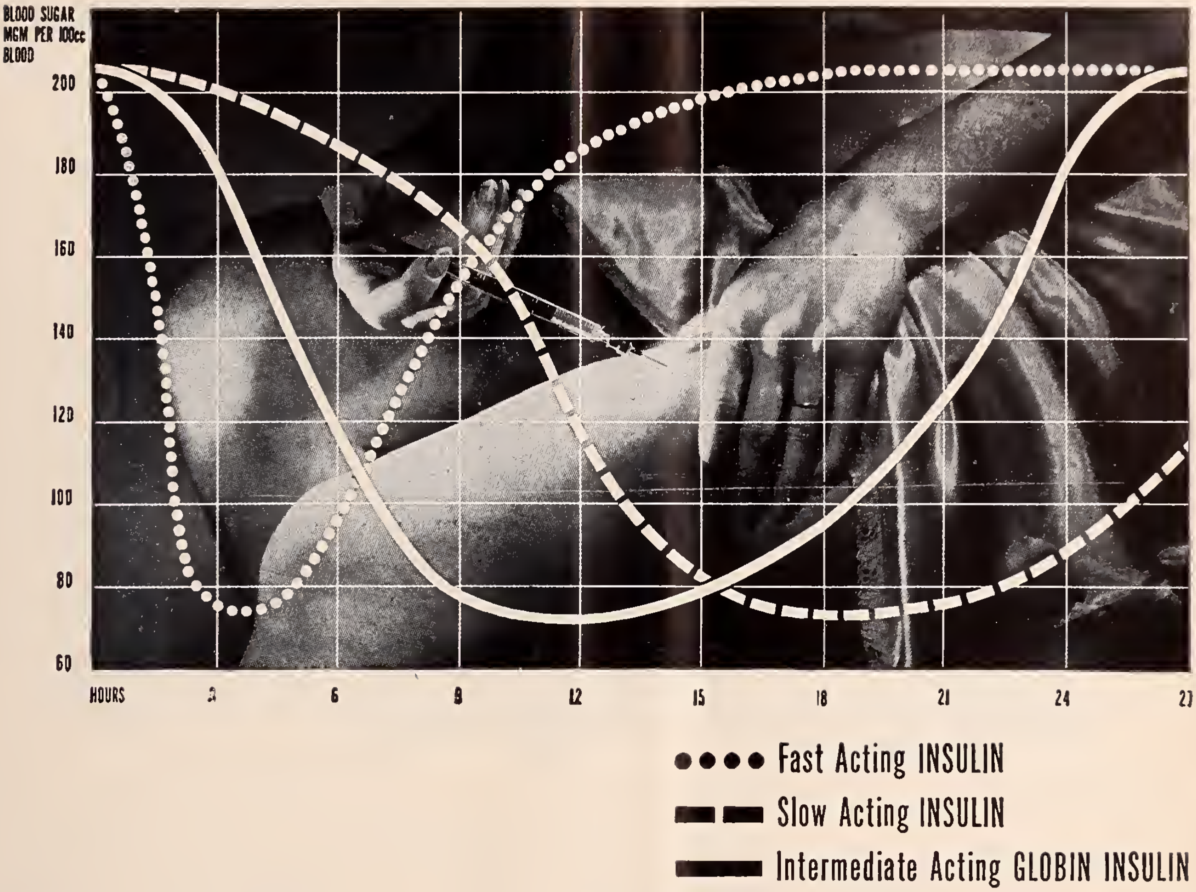

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Allergist, Samuel Merritt Hospital,
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TWENTY-FIVE YEARS AGO

(Continued from Page 48)

that such a standard can ever be more than relative and it must vary with the period, the race, the social status and the educational advantages enjoyed by the individual under consideration. Dependent upon variations in these factors and especially with the social conditions, there occur fluctuations in the mental state, affecting not only individuals, but groups and peoples, spreading as it were by contagion and swinging far to the pathological side in the less stable members of the community. . . .

From an Article on "Early Diagnosis of Pulmonary Tuberculosis," by John C. King, M.D., Banning, Calif.—Some time ago a paper was printed in a prominent medical journal savagely attacking tuberculosis specialists, particularly those who conduct sanatoria. The author, who had attained the rank of Colonel, was a surgeon in the regular army. He claimed he had been examined; pronounced the victim of incipient tuberculosis; sent to a sanatorium for six months and then discharged cured. He further claimed he had never had tuberculosis; that, because of faulty diagnosis, he had been subjected to unnecessary mental distress and financial sacrifice; and furthermore, that a large number of sanatorium inmates are suffering from similar injustice. Twenty years ago an Indian, named Siguando, came under my care for serious tuberculosis. He had hemorrhages, cavities, fever, T.B. in his sputum. He completely recovered. Every year or two he comes to my office for a chat, and always jokes about my mistake when I pronounced him consumptive, assuming that had I been correct he would have died.

The Colonel and the Indian are about on a par. . . .

(Continued on Page 58)

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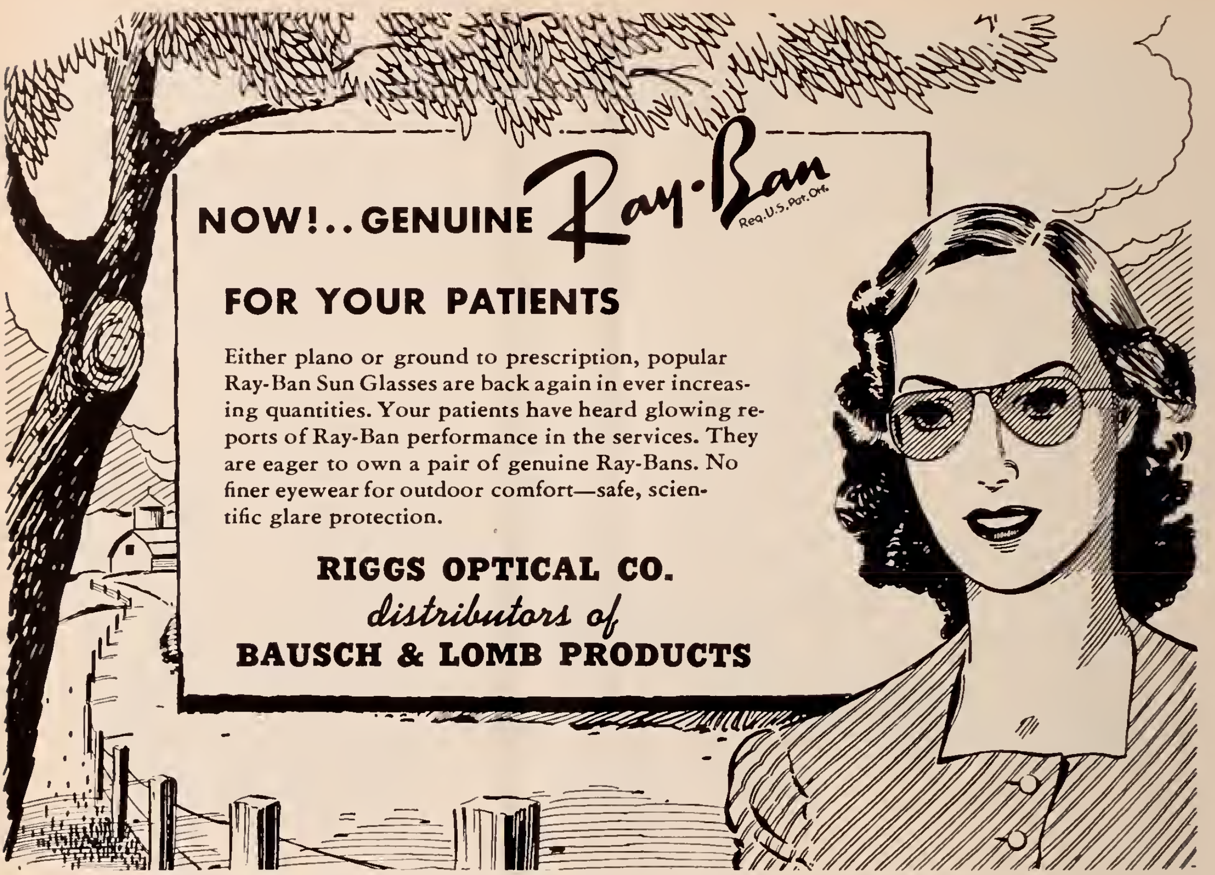

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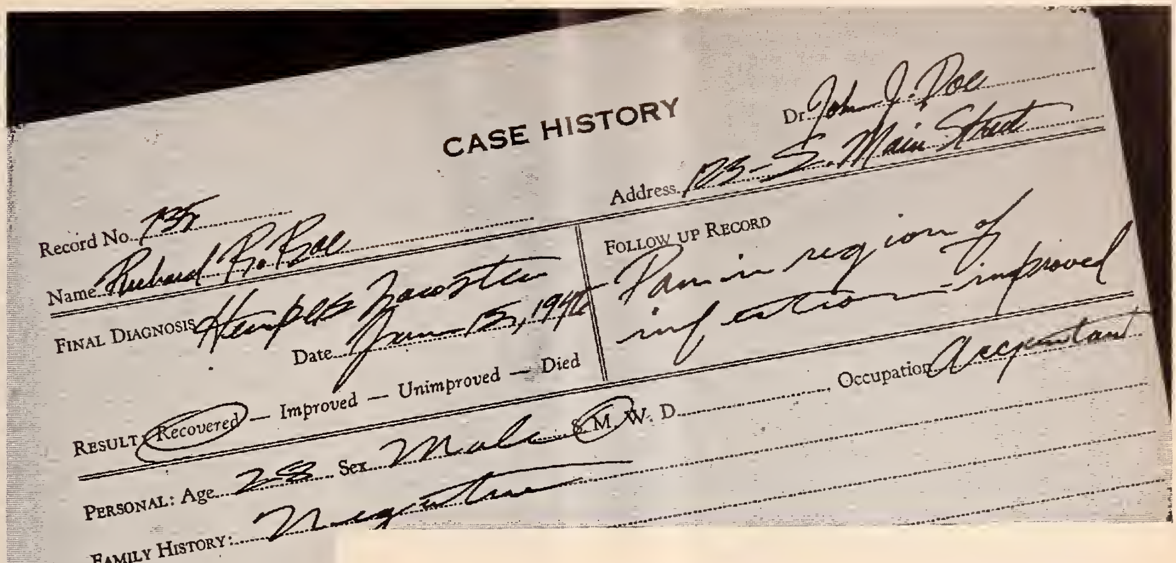

CASE HISTORY

Dr. John J. Doe
Address 123 S. Main Street
Record No. 135
Name Richard R. Roe
Final Diagnosis Herpes Zoster
Date June 15, 1942
Follow up Record Pain in region of infection — improved
Result [✓ Recovered] — Improved — Unimproved — Died
Occupation Accountant
Personal: Age 28 Sex Male S [✓ M] W. D.
Family History: Negative
Habits:
Past Health:
Present Conditi
Physical E
Temp
Head: (i

CASE HISTORY OF WHAT HE DID IN THE INFANTRY

Lieutenant ———, medical corps, with infantry in Philippines. Rugged conditions not ideal for practice of medicine. Wounded by bomb fragment, hospitalized, then discharged. Interest in setting up own practice; had some money but not enough to get started. Informed that "G. I. Bill of Rights" guarantees 50%, or $2,000, of certain business loans to veterans. Visited Bank of America, found complete lending service, offering sound credit. Under Bank of America **Vet-loan Plan,** which supplements "G. I. Bill," was extended credit totaling $4,600. Now established in own office. Convenient monthly **Vet-loan** payments arranged.

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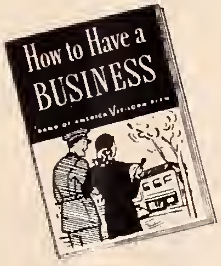

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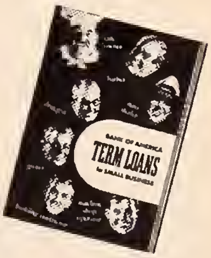

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TWENTY-FIVE YEARS AGO

(Continued from Page 52)

From an Article on "Modern Radiotherapy," by Frederick Hase Rodenbaugh, M.D., San Francisco.—Many clinicians fail to recognize the extensive application of radiotherapy in modern medicine. The term, radiotherapy, implies the employment of both radium and the x-ray in the treatment of disease, and the clinician of today should be as familiar with the scope and the limitations of radiotherapy as with surgery or any other therapeutic agent.

As modern radiotherapy is of comparatively recent development, there is naturally much discussion as to its method of application and its value in any group of cases. Obviously with this as with other forms of therapy, no group of cases is amenable to any single agent. Experience has taught that only by a proper combination and coördination of x-ray and radium with surgery and electrothermic methods can the best results be obtained. . .

Care of Communicable Disease—As It Developed

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1919

There is no reason why contagious wards should not be attached to a general hospital. Chief advantages of such an arrangement are economy and better service to patients.

D. L. RICHARDSON, M.D., The Modern Hospital, August

1930

Dovetailing of the contagious unit with the organization and plan of the general hospital represents the most recent emphasis upon this factor and thus far, results seem to have justified the trend.

F. G. CARTER, M.D., The Modern Hospital, April.

1939

There is ample evidence to prove that proper service

(Continued on Page 62)

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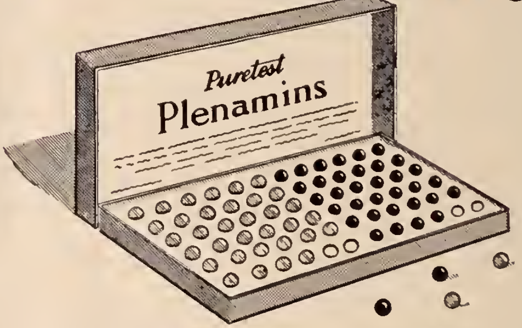

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1. Dickinson, R. L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
2. Eastman, N. J., and Scott, A. B.: Human Fertility 9:33 (June) 1944.
3. Warner, M. P.: J. A. M. A. 115:279 (July 27) 1940.

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GLENDALE 6, CALIF.

CARE OF COMMUNICABLE DISEASE

(Continued from Page 58)

techniques cause isolation wards to be more free from cross infections than the wards of a general hospital.

Clement C. Clay, M.D., Hospitals, June.

1943

Acute communicable diseases can be treated in general hospitals under the special safeguards of proper construction, adequate sterilization equipment and a sufficient force of trained personnel. Communities that lack a special hospital for acute communicable disease cases are justified in demanding that their hospitals make provision for the treatment of these.

Dora G. Tolle, M.D., The Modern Hospital, January.

1945

There is increasing need in this country for the creation of isolation wards in general hospitals. Such units could be established at little expense. With competent medical and nursing supervision the danger of cross infection within the hospital would be negligible.

Richard W. Maxwell, M.D., The Journal of the Missouri State Medical Association, February.

1946

I see a growing need for acute general hospitals to provide proper facilities for the care of acute communicable diseases.

Hundreds of American communities, while well served for other diseases, leave patients with communicable conditions to be treated inadequately at home or else risk their transportation to some distant communicable disease institution.

These special voluntary or tax-supported hospitals are

(Continued on Page 64)

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*When used in conjunction with the treatment of vaginal infections the reason for an acid reacting douche such as S-X 12 becomes apparent, as the pH of the vaginal mucosa is then typically alkaline and the normal flora of Doderlein bacilli is absent or reduced. S-X 12 is helpful in this condition, particularly when used with the Servex Trich Powders Nos. 1 and 2.

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CARE OF COMMUNICABLE DISEASE

(Continued from Page 62)

themselves a problem. They may stand idle most of the time and, outside of large centers of population, often represent economic waste, and, because only skeleton staffs are maintained, they often provide inadequate service.

In the light of perfected nursing techniques and present knowledge of the control of cross-infection, there seems less and less excuse for the general hospital to deny this aid to its community.

I would be the last to advocate carless or inadequate methods in the housing or care of these patients nor, indeed, any procedure which would endanger other patients. But, to a large extent our past fears have been unreasoning and not justifiable in the light of modern scientific knowledge.

As a member of the Commission on Hospital Care I am particularly anxious that the rôle of the general hospital be re-defined in a manner to take full advantage of medical progress to enable the hospital to fulfill this and other demands of a changing society.

CLAUDE W. MUNGER, M.D., Director.
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(Note. Above excerpts from Hospital Survey News Letter, January, 1946. Address, 22 East Division Street, Chicago, 10.)

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—Cicero, *De Senectute*, Ch. xix, sec. 70.

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President, Edward C. Sherman, 784 Marsh Street, San Luis Obispo.
Secretary, G. D. Kelker, 1114 Marsh Street, San Luis Obispo.
Meeting, *Fourth Wednesday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, A. G. Miller, 205 Third Avenue, San Mateo.
Secretary, J. Paul Sweeney, 1149 Rosewood Avenue, San Carlos.
Meeting, *At call of President.*

Santa Barbara County Medical Society
President, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Secretary, Charles A. Preuss, 1317 Santa Barbara Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, Charles A. Fernish, 226 Sainte Clare Building, San Jose 23.
Secretary, Fred W. Borden, Sainte Claire Building, San Jose, 23.

Santa Cruz County Medical Society
President, Ruth A. Frary, 123 East Third Street, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

Shasta-Trinity County Medical Society
President, L. C. Mosher, Bieber.
Secretary, Julius M. Kehoe, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, Richard W. Jones, 106 South Broadway, Yreka.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, John W. Green, Box 539, Vallejo.
Secretary, Clark T. Alexander, 731 Sonoma Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.*

Sonoma County Medical Society
President, William Stegeman, 534 B Street, Santa Rosa.
Secretary, Raimond F. Clary, 1616 Fourth Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, J. Lyle Spellman, P. O. Box 1412, Modesto.
Secretary, Richard R. Treadwell, P. O. Box 801. Modesto.
Meeting, *Second Friday, 7:30 p.m., Hotel Hughson.*

Tehama County Medical Society
President, James L. Faulkner, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, George Keiper, Bank of America Building, Visalia.
Secretary, Irvin H. Betts, 222 West Willow Street, Visalia.

Ventura County Medical Society
President, A. W. Cruden, Saticoy.
Secretary, George H. Arnold, Route 2, Box 12, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Charles S. Roller, 604 Woodland Avenue, Woodland.
Secretary, Emery Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, Leon M. Swift, Box 244, Marysville.
Secretary, D. Ermorine Edwards, 725 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

(For roster of C.M.A. committees and other organization, see last month's issue.)

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Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento. (Main 2548.)

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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

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Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WEst 8000, Extension 75.

Barlow Medical Library (Los Angeles County Medical Association), 634 So. Westlake, Los Angeles 5. Phone FItzroy 7694.

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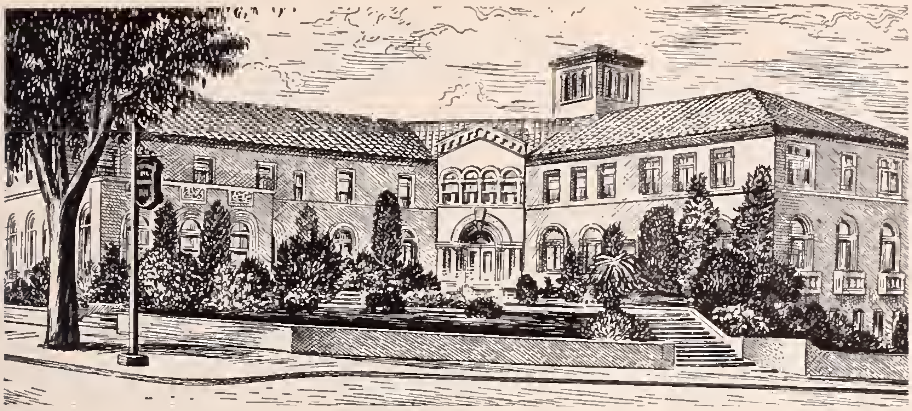

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 334)

fact that social workers are the vanguard of any army of laymen, who, with awakened conscience and eyes opened to the possibility of diminishing the enormous losses of disease, are working inevitably toward an era in which preventive, social and group medicine will absorb a large amount of his effort. . . .

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EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Poison Oak Dermatitis," by H. E. Alderson, M.D., San Francisco, and H. J. Pruett, M.D., San Francisco.—The poison oak plant (rhus diversiloba) grows extensively along the Pacific Coast where the soil is not too dry, up to elevations of five or six thousand feet. It belongs to the same family as the "poison ivy" plant (rhus toxicodendron) and "poison sumac" (rhus venenata).

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Syme in 1906 concluded that it was a non-volatile glucoside containing rhamnose, fisetin and gallic acid. This is the accepted belief today.

Von Adelung in 1913, proved experimentally that the poisonous agent was non-volatile. . . .

Poison oak dermatitis is a condition with which the laity as well as the medical profession of California

(Continued on Page 12)

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TWENTY-FIVE YEARS AGO

(Continued from Page 7)

have been quite familiar since "pioneer days," and its treatment, consequently, is an old problem. Many are immune to this trouble and remain so for years; but this "natural" immunity often is known to disappear. The writers have never had poison oak dermatitis, although exposed often since infancy; but they fully expect to lose this immunity some day. Here in California one often sees individuals who claim that their immunity was induced by eating the leaves and small twigs of the plant, which procedure made them very sick for a few days. This eating of the leaves is common practice in some localities, the method varying from using the raw plant to drinking a "soup" made from the same. Recently, our attention was called to the apparently successful use of the latter method by an engineering outfit in the mountains. So numerous were the cases of dermatitis venenata amongst the men that it was feared by the company's surgeon that the work would have to be abandoned, when the men solved the problem themselves by preparing a "soup" from the plant and drinking it ad libitum. Then the number of cases became very greatly reduced, according to the surgeon for the company. . . .

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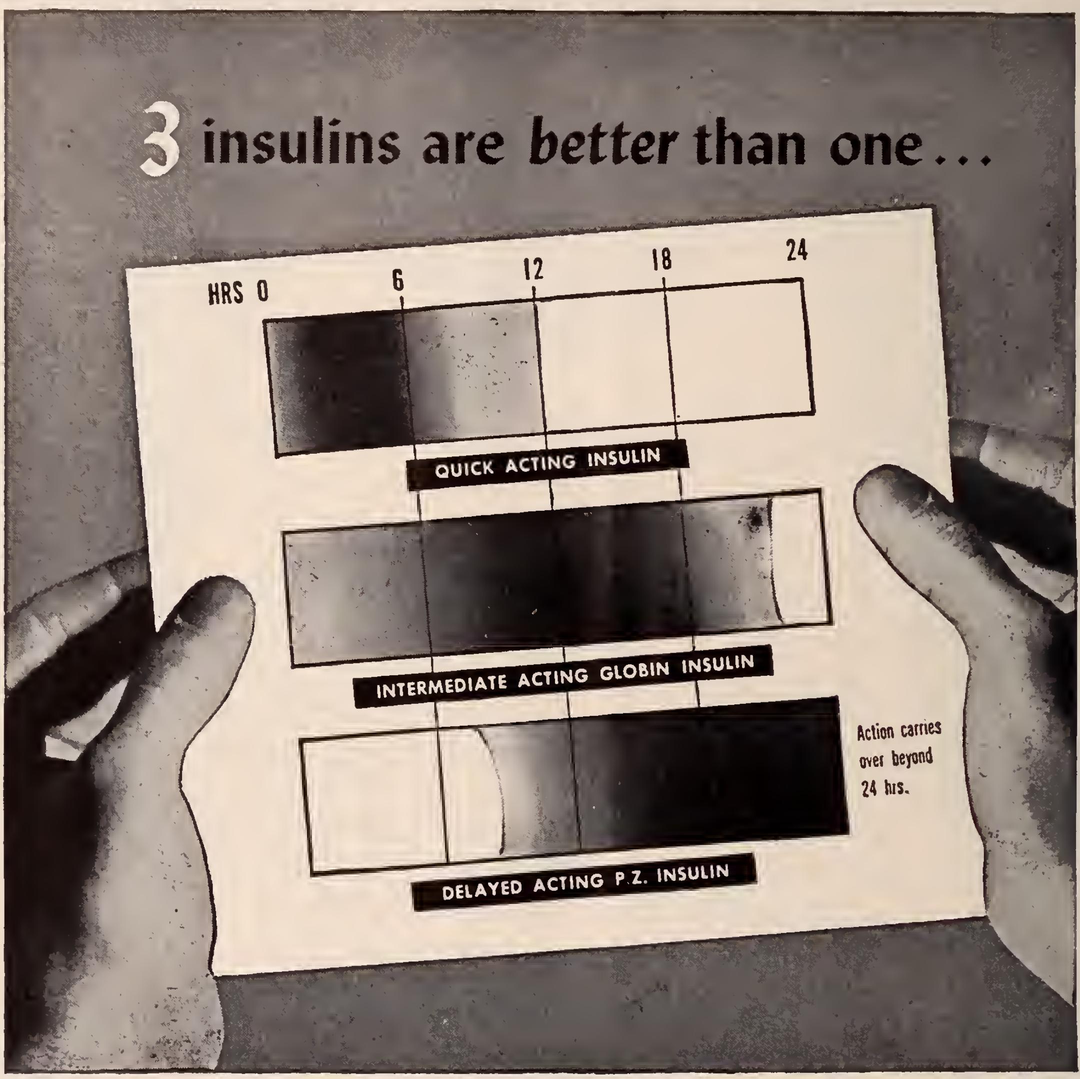
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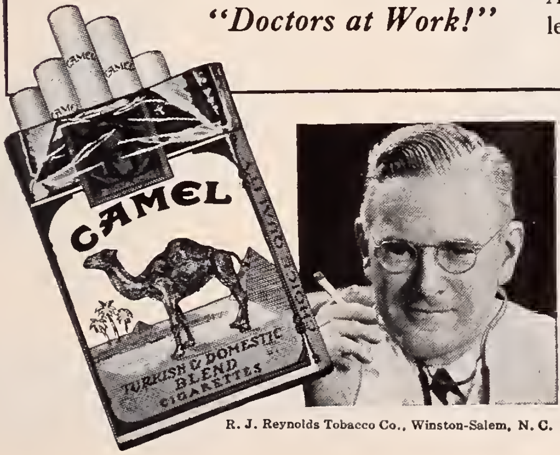
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FOR DETECTION OF ACETONE IN THE URINE

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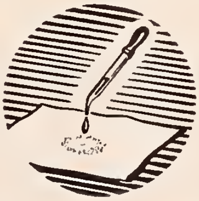

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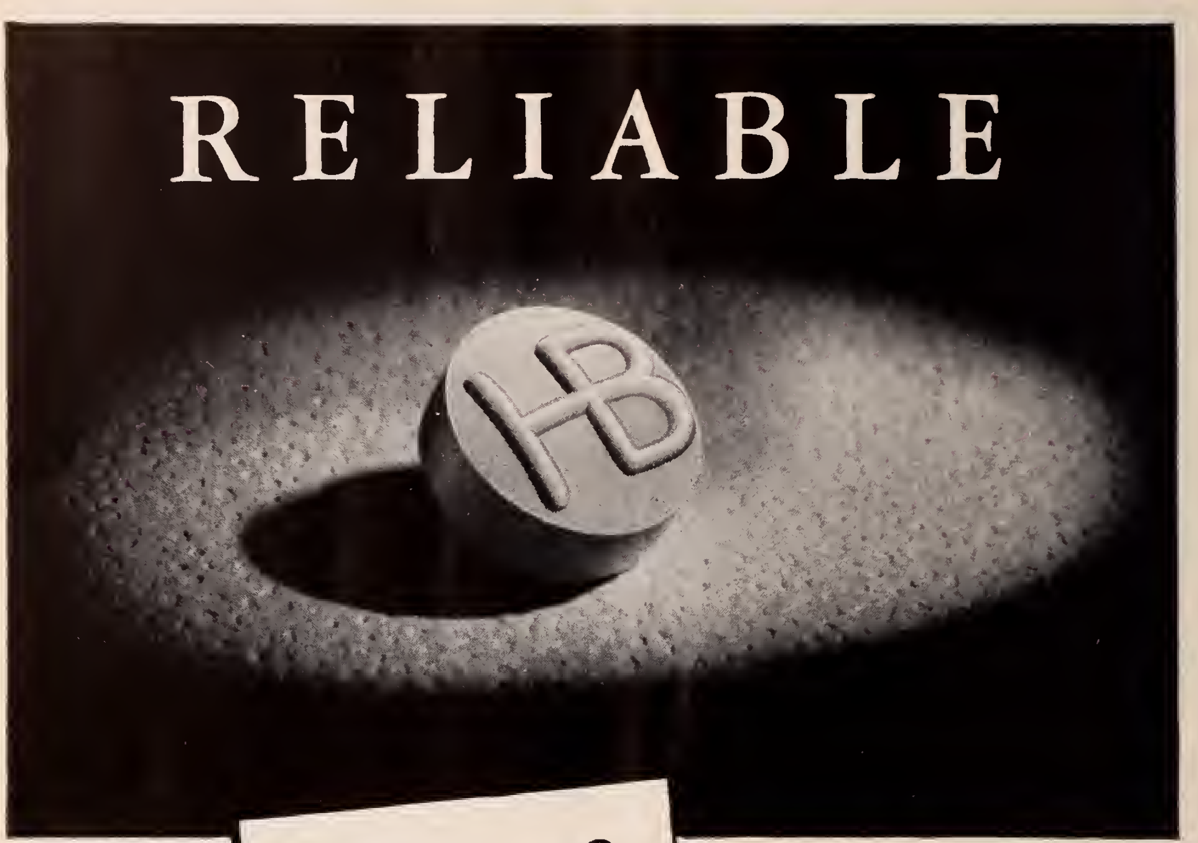

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TWENTY-FIVE YEARS AGO

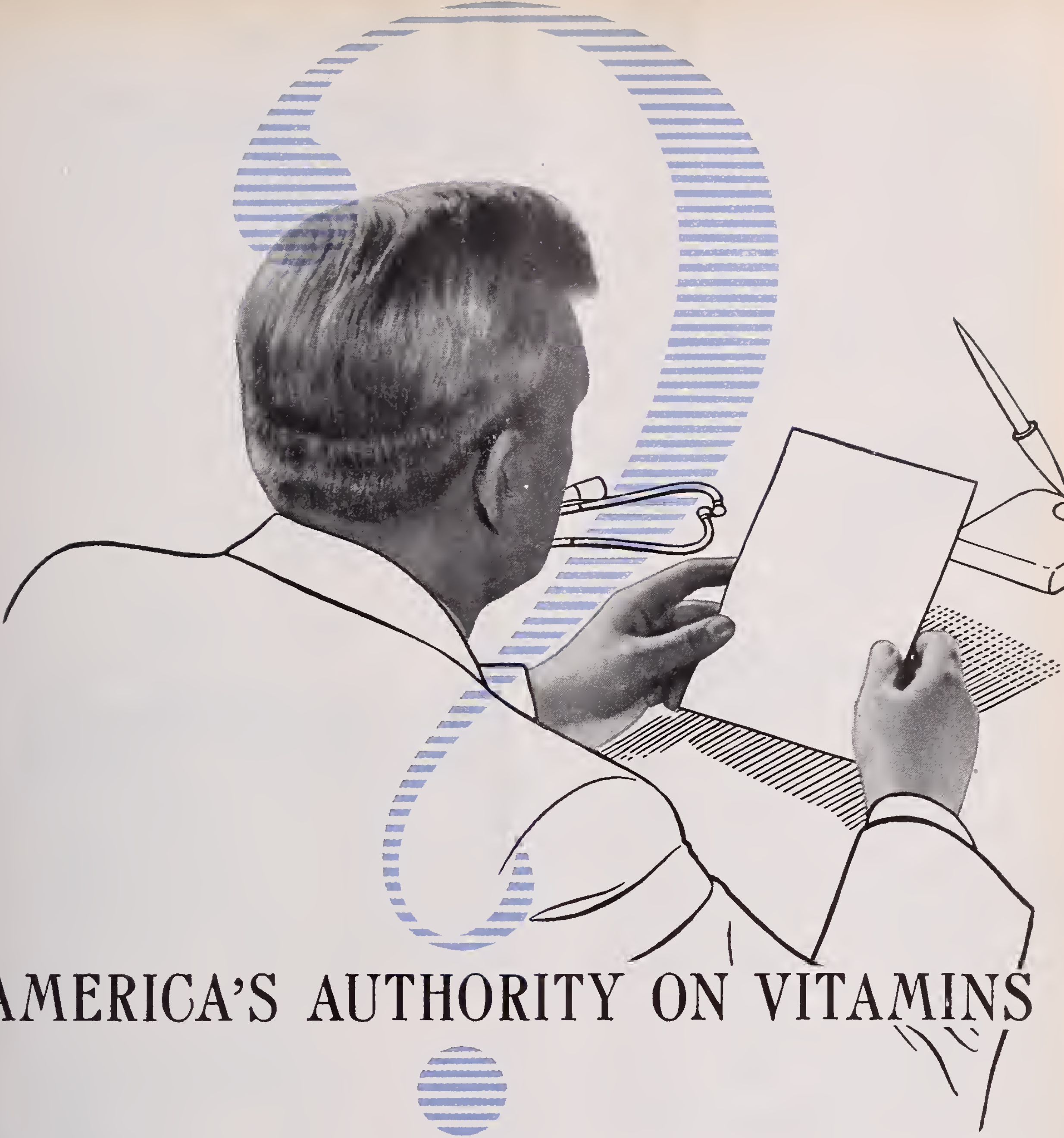
(Continued from Page 12)

some luetic involvement as determined by this test, performed at a reliable San Francisco laboratory, was 166 or 10.93 per cent. . . .

From an Article on "Ante and Postoperative Treatment," by C. L. Lowman, M.D., Los Angeles.—The last five years has emphasized and disseminated, more than the previous twenty years, many features in surgical treatment which orthopaedic surgeons have been using for a long time. Preventive measures, anteoperative, and postoperative measures, are based on the functional outlook with definite relation to future function and efficiency. Previously there was a general tendency on the part of many surgeons to be so deeply interested in the pathological process and the technique of the surgical procedure to be used in its eradication, that the question of physiological disturbances of function was given little consideration. Without minimizing the value of a thorough knowledge of pathology, it has been very evident that things functional have received comparatively little attention. . . .

From an Article on "Trauma—Its Relation to Nervous Diseases of Undetermined Pathology," by Joseph Catton, M.D., San Francisco.—In assigning to trauma causal place in relation to diseased conditions, it has too often been a fact that medical men have dealt with the subject with absolute empiricism. What has been true in this connection, as regards medicine in general, has been true, likewise, as regards neurological medicine. Physicians who are scientific, those who demand pathologic cause for symptomatic effect, must satisfy certain definite criteria

(Continued on Page 24)



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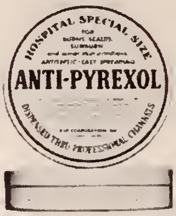

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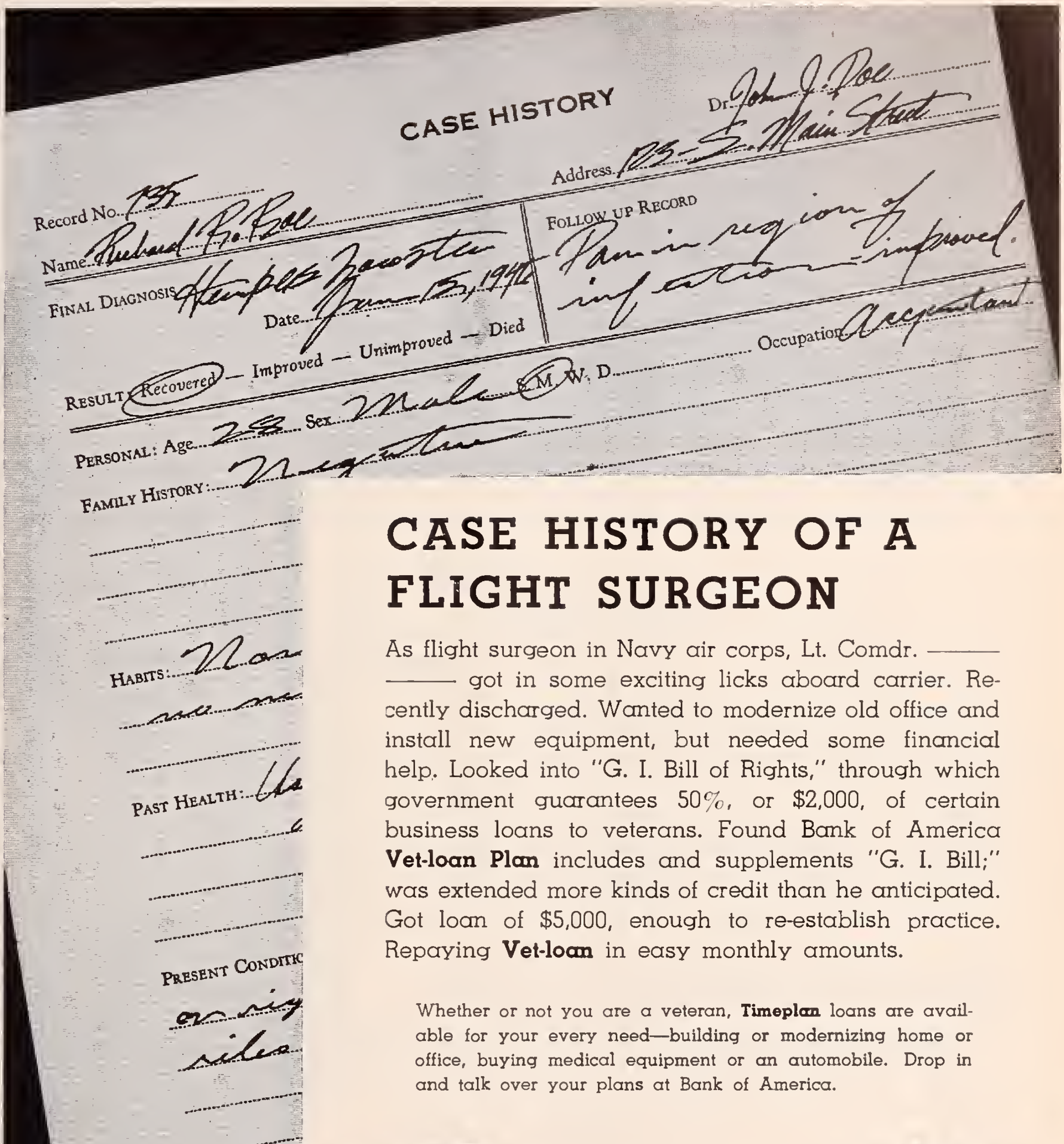

CASE HISTORY

Record No. 135

Name Richard R. Roe

FINAL DIAGNOSIS Herpes Zoster

Date June 15, 1946

RESULT: [✓ Recovered] — Improved — Unimproved — Died

Dr. John J. Doe

Address 123 S. Main Street

FOLLOW UP RECORD Pain in region of infection—improved.

Occupation Accountant

PERSONAL: Age 28 Sex Male S [✓ M] W. D.

FAMILY HISTORY: Negative

HABITS:

PAST HEALTH:

CASE HISTORY OF A FLIGHT SURGEON

As flight surgeon in Navy air corps, Lt. Comdr. ——— ——— got in some exciting licks aboard carrier. Recently discharged. Wanted to modernize old office and install new equipment, but needed some financial help. Looked into "G. I. Bill of Rights," through which government guarantees 50%, or $2,000, of certain business loans to veterans. Found Bank of America **Vet-loan Plan** includes and supplements "G. I. Bill;" was extended more kinds of credit than he anticipated. Got loan of $5,000, enough to re-establish practice. Repaying **Vet-loan** in easy monthly amounts.

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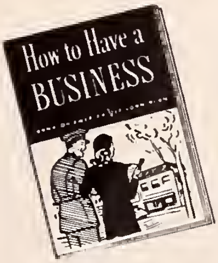
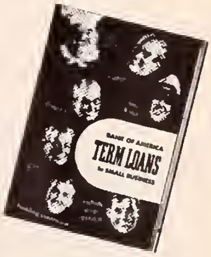


"How to Have a Business" and "Term Loans for Small Business" are two helpful Bank of America booklets which you might like to read. They are yours for the asking at any branch.



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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

in their minds before calling trauma a factor in the production of a given disease. This paper will consider but one of the class of nervous diseases, whose pathology has not yet been definitely and finally determined. Such consideration as is given to this particular disease and its relation to trauma, may be applied, in toto, to the other neurological conditions of undetermined pathology. . . .

From an Article on "An Essential in Reconstructive Surgery—'Atraumatic' Technique," by Sterling Bunnell, M.D., San Francisco.—Reconstructive surgery has been confronted by two great obstacles, infection and fibrosis. In order to overcome these, the following methods have been formulated into what I have termed "atraumatic" technique.

Through the impetus of the industrial accident compensation laws, and lately through the necessity of reconstruction of the injuries sustained during the war, many surgeons have turned their attention to this line of endeavor.

Experience teaches us that ordinary surgical procedure is not sufficient for success, and we have been brought to the realization that a new surgical technique must be developed in order to achieve results in reconstructive surgery. Unlike most surgery, which consists in opening infected areas and in removing diseased tissues, reconstructive surgery consists in building up parts, so that motion and function will result. The difference is like that between katabolism and anabolism, and the technique which has been adequate for one has proven inadequate for the other. . . .

(Continued on Page 28)

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TWENTY-FIVE YEARS AGO

(Continued from Page 24)

From an Article on "Acute Brain Injuries," by Thomas O. Burger, M.D., San Diego.—Injuries of the head do not decrease perceptibly in spite of the "safety first" propaganda. There has also been an alarmingly high death rate until the past few years, but improved diagnostic methods, better judgment as to what cases are operable, and still better technique have reduced the mortality from 53 per cent or 28 per cent, depending on clinics. . . .

From an Article on "The Neurological Aspects of Visceroptosis," by Thomas G. Inman, M.D., San Francisco.—Visceroptosis, not infrequently discovered accidentally in the course of the routine examination, may be present in a marked degree without, apparently, causing a single subjective symptom. Attention is attracted to the alimentary canal because of the presence of other local conditions such as constipation, indigestion, meteorism or mucous colitis and it has been customary to associate with the visceral ptosis certain distant symptoms, referable especially to the nervous system. Of these, weakness, nervousness, vertigo, syncope and insomnia are said to be the most frequent. It is extremely doubtful, however, if any one of these symptoms may truthfully be said to be due to the ptosis alone. . . .

Excerpts from County Societies:

San Francisco County—Dr. Adolph Barkan's Donation for Historical Study.—With the aid of a gift from Dr. Adolph Barkan, emeritus professor of the Stanford Medical School, Stanford University is gathering in the Lane

(Continued on Page 32)

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- ★ Well Tolerated and Effective Subcutaneously
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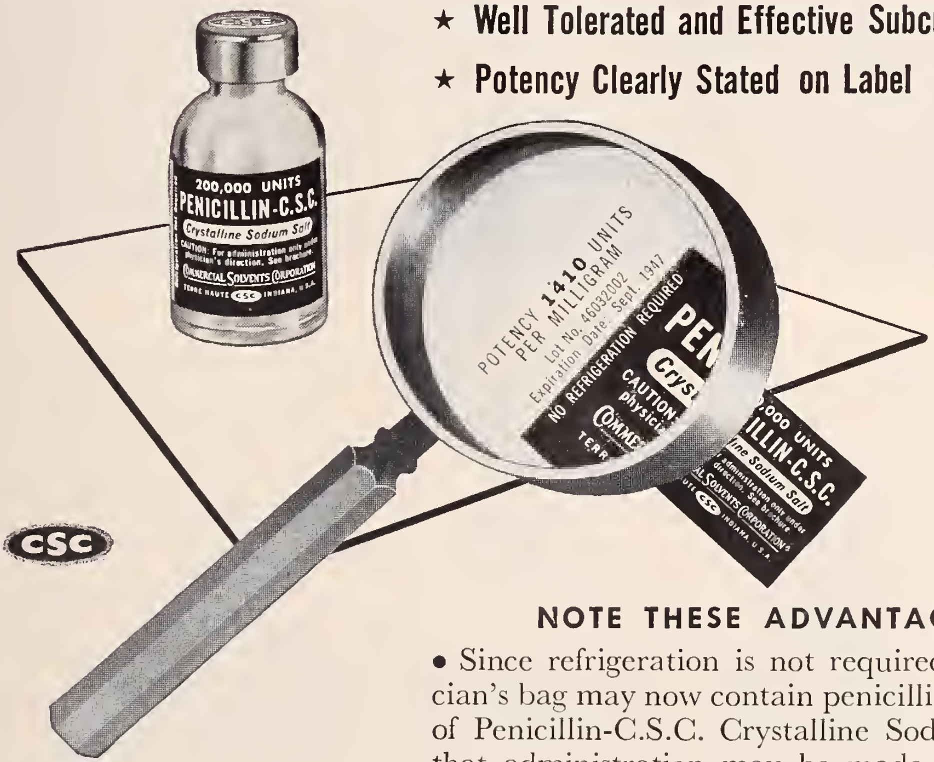
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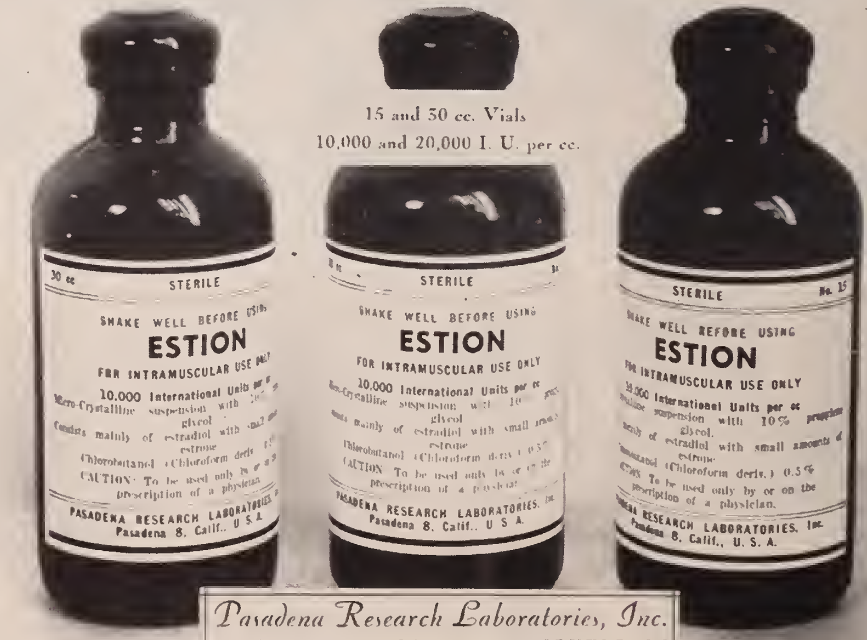
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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

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Dr. Barkan will give $1,000 a year for the next three years, to which the university will be able to add from the income from certain Lane Library Foundations $1,500 a year, making a total fund of $7,500, all of which will be expended on books concerning the history of medicine. . . .

Excerpt from an Obituary: Dr. Stanley P. Black, Los Angeles.—Stanley P. Black, A.B., M.D., patriot, physician, pathologist, humanitarian, is dead. Perhaps no member of the profession in the last decade has left so indelible an imprint on the lives of the community in which he lived and worked as this earnest, hard-working physician. . . .

Quarterly Review of Obstetrics and Gynecology

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From a great diversity of domestic and foreign journals there is brought together in the Quarterly Review of Urology a most comprehensive compilation of all the significant advances in every branch of urology. All of the essential details of the new diagnostic methods and tests, as well as every new therapeutic procedure are presented so that the busy practitioner may safely and successfully employ these new methods in his own practice. Especial attention will be given to the illustrations to depict modifications and advances in surgical technique. In medical therapy and chemotherapy, etc., exact dosages, indications and contra-indications will be so presented that the reader will have specific informative clinical assistance that will not require further reference. Each issue of the Quarterly Review of Urology will contain a classified table of contents, a cross reference subject index and an authors index. The concluding number of each volume will include a cumulative cross reference subject and authors index so that all of this vital information may be quickly available.

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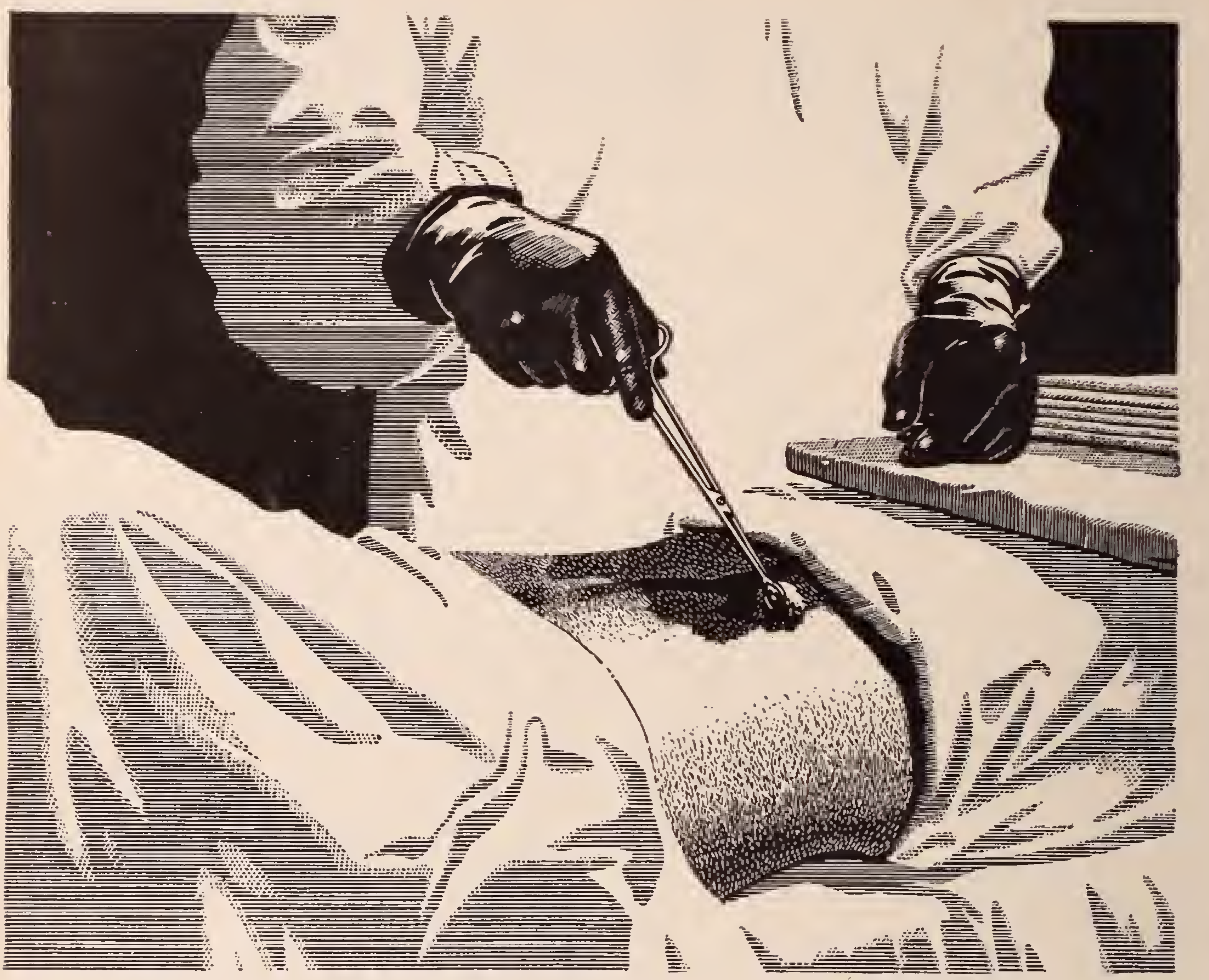

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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

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F. Burton Jones.........................Vallejo 1947
R. H. Sundberg.........................San Diego 1948
George H. Kress, Secretary-Editor...... San Francisco ex officio

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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

ON ANNUAL SESSIONS AND REGIONAL CONFERENCES

The 75th Annual Session.—The 1946 Annual Session of the California Medical Association will have come and gone before this May issue of CALIFORNIA AND WESTERN MEDICINE is placed on the desks of C.M.A. members. In the April "Pre-Convention" number of the OFFICIAL JOURNAL appeared the programs of the general and section meetings of the Scientific Assembly. An inspection of the topics of the Association's thirteen scientific sections there given should convince any Doubting Thomases that the desire of physicians to keep abreast of recent progress in the healing art exists as earnestly today as in the past. For physicians who are interested in the activities of organized medicine, the reports of officers, committees, and component county societies, gave clarifying evidence concerning the large number of active workers who are giving freely of time and effort on plans and procedures designed to promote the best interests of medical practice and the public health.

Also, before now, the business and other happenings at the 75th annual session, held in Los Angeles on May 7-10, will have been transmitted orally to county societies by their delegates. The official proceedings of the House of Delegates will probably appear in the June issue of CALIFORNIA AND WESTERN MEDICINE. These should be scanned by every member who would do his bit as a member of the medical profession by keeping in touch with policies outlined and actions taken through his duly elected representatives.

* * *

A Large Society in a Great State.—The increasing growth of the California Medical Association, now possessing a membership in excess of 7,000, making it the third largest constituent state medical society in the United States—and located as it is in a commonwealth credited with 158,297 square miles, and a population of 9 million persons,—suggests the thought that the time may not be far distant when, in addition to the one annual session for the entire Association, it may be desirable to complement that gathering, every year or so, through presentation of two or three Regional Scientific Conferences.

* * *

C.M.A. Cannot Meet Always in Los Angeles.—It is generally agreed that the transportation and hotel accommodation difficulties that recently have been so much in evidence, are not conducive to bringing out an attendance at an annual session commensurate with the size or influence of the California Medical Association.

During the last several years, it has been necessary to continue to meet at The Biltmore in Los Angeles, that being the only hotel in California at the present time, of sufficient size to provide an adequate number of meeting rooms, and give also limited facilities for physician guests.

However, the California Medical Association cannot continue to meet only in one city—as it has done during the last three years.

Granted that one major annual meeting of the California Medical Association is necessary—particularly for the transaction of business by the House of Delegates—would it not be possible to consider for this large State of California—second in size in the Union—the desirability of holding two or more regional conferences of the Scientific Sections of the Association?

In the northern division of the State, such midyear conferences could be held in different cities—as at San Francisco, Oakland, Fresno, or Sacramento. In the southern section, meetings could convene, say at San Diego, Riverside, Long Beach, Pasadena, or Los Angeles.

* * *

Advantages of Regional Conferences.—Such regional conferences could be made of real value by keeping members in these respective communities—some of whom have only casual interest in their medical societies—in better touch with their fellows of their own geographical sections, and with the scientific and organizational work that is being carried on by colleagues whom they meet from day to day. The medical profession is benefited through such contacts.

* * *

Comparison with Eastern States.—States with much smaller geographical areas and populations than California all have their own constituent state medical societies. If the ground area of California is divided by two, it still has more than 75,000 square miles for each half; and in each such half area could be placed states as follows:

Rhode Island (1,248 square miles).
Delaware (2,370 square miles).
Connecticut (4,965 square miles).
Massachusetts (8,266 square miles).
Maryland (12,327 square miles).

These six states taken together would only total about one-half of one-half of California's total area!

Organizations such as the American College of Surgeons have already learned the advantages to be derived from regional conferences, as witness in recent years, separate meetings in San Francisco and Los Angeles.

When the present C.M.A. Constitution was adopted in May, 1929, provision was made for Councilor District Societies (Article V, Section 13), so the basic thought or plan here mentioned, is not new.

Above Is Submitted for Discussion.—What has been written above is submitted only to provoke thought on the subject. If the California Medical Association continues to grow—and it is growing in leaps and bounds as proven by a listing of more than 200 applicants for membership in one component county society, as given in a recent issue of the *Bulletin of the Los Angeles County Medical Association*—it is logical to assume that ways and means must be found through which members who are engaged in research or clinical studies may find legitimate outlets for the presentation of their work. These workers cannot all attend the American Medical Association sessions; and their studies are worthy at times of larger audiences than those available in their local county societies.

Unless our own State Medical Association, even though it be third in the list in number of members, develops plans aiming at objectives noted above, it is possible it may fail somewhat in its capacity for service to its own members, and to a certain extent, in service to the people of California.

WASHINGTON HEARINGS ON WAGNER-MURRAY-DINGELL BILL: S. 1606

Excellent Reports Are Appearing in J.A.M.A.—Public hearings on "Senate Bill 1606—To Provide for a National Health Program"—began on April 2, 1946, in Washington, before the Senate's Committee on Education and Labor, James E. Murray, Senator from Montana, presiding.

S. 1606 is generally referred to as the Wagner-Murray-Dingell Bill, and in popular understanding is the successor of the compulsory health insurance bill first introduced in 1939, as S. 1620, by the same Congressional sponsors.

The public reaction against the compulsory features of the predecessors of present S. 1606 was sufficiently great to presumably lead Senators Wagner of New York, and Murray of Montana, and Congressman Dingell of Michigan, to carefully avoid the use or implication of the word "compulsory" in S. 1606.

* * *

Incidents at First Hearing on April 2, 1946.—The first hearing on April 2 was marked by a sharp discussion between Chairman Murray and Senator Taft of Ohio, also a member of the Committee. The report of the interchange of noncomplimentary expressions was given in some detail in the *Journal of the American Medical Association* for April 13, on pages 1021-1023.

In that issue, *J.A.M.A.* prints 15 pages of a condensed verbatim report, and in its April 20 number, eight pages.

Physicians who will take the time to scan the *J.A.M.A.* reports will be able to understand better the forces that are being aligned against scientific and organized medicine. It is illuminating, even though depressing at times, to read how clever are the health insurance proponents when they advocate adoption of the procedures that have been incorporated in S. 1606. Also, how their dogmatic statements concerning theoretical plans they have espoused turn to keen evasiveness and "I cannot answer that question" replies, when they are too apt to be confounded with their own arguments.

At the beginning of the hearing, the sponsors of S. 1606, Senators Wagner and Murray and Congressman Dingell read into the record their respective statements, and were followed by Senator Claude Pepper of Florida, Mr. Watson B. Miller, Federal Security Administrator, and Medical Director J. W. Mountin of the U. S. Public Health Service, and others.

* * *

Some Excerpts from the Testimony.—On pages 1034 and 1035 of *J.A.M.A.* for April 13, one can find the following:

"Senator Murray: Some have suggested that the bill setting up the Surgeon General and providing for the administration of this act would create a dictator under the Surgeon General. Have you studied that?

"Dr. Mountin: I hope that we humble servants in government have not risen to that position. We have always regarded ourselves as the humble servants of the people and responsive to the will of Congress. I hope that that is our record. . ." [*sic.*]

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"Senator Murray: Doctor, you have not referred to the National Medical Advisory Policy Council which has been set up here, and the work that the Advisory Council has done in establishing professional standards. . ."

"Dr. Mountin: Well, it provides that the Surgeon General [U.S.P.H.S.] shall set up at the Federal level an advisory council. I do not have the exact wording, but in general the Council shall be representative not alone of the professional bodies but of the institutions that are concerned with care, and with groups that are concerned with receipt of service; so we have both the point of view of the producer and the recipient of service. The act also requires that he shall consult with the council on matters of policy, and that he shall report to Congress on the use that he has made of these councils. It provides for regional councils that parallel the national one in many respects, so that you have that balancing of authority. It is not exactly authority, but that participation, I should say, of professional and consumer groups all the way down the line in the administration of the act. . . ."

* * *

"Advisory Boards," Theoretically and Realistically.—To go into a discussion of the above quotations is not possible in the space allotted to this column. It may be stated, however, concerning the proposed National Medical Advisory Policy Council that the experience of physicians and others with so-called "advisory councils" is that they rarely function as wisely as the high-sounding phraseology creating them would have us believe. Witness, for example, the manner in which the Children's Bureau of the U. S. Department of Labor hand-picked its advisory council for the Emergency Maternity and Infant Care (E.M.I.C.) program, and how the constituent state agencies that were supposed to administer on state and local levels were hamstrung through the simple procedure of not forwarding funds from Washington, whenever the state agency failed to comply with the directives sent forth on the "national level" from Washington.

Yes, it is easy to talk about how advisory bodies can promote broad approaches to solutions of problems, but in practice, such advisory bodies rarely are given any real authority, and this realistic experience applies especially, when such a council is "advisory" to a governmental or bureaucratic body.

* * *

J.A.M.A. Reports of the Hearing Are Worthy of Perusal.—In its April 20 issue, *J.A.M.A.* presents much of the report of Mr. Arthur J. Altmeyer, chairman of the Social Security Board, who has been well established in the public mind as a vigorous supporter of legislation of the Wagner-Murray-Dingell type. If space permitted, attention could be called to statements in which, in spite of being a supposed super-expert on the subject of compulsory health insurance, his replies were lacking in factual information.

Physicians who do not take the time to scan these verbatim digests of hearings on S. 1606, are denying themselves an excellent opportunity of learning along what lines the leaders among the proponents of "political medicine" are thinking.

It will be interesting to follow the reports of subsequent hearings before Senator Murray's Committee.

ON HOSPITALS

Place of Modern Hospitals in Present-Day Medical Practice.—If the modern hospital is left out of the picture, present-day medical practice is difficult to envisage. Older members of the profession know how many have been the important improvements in hospital procedures that have taken place since the days when they left medical schools to take up private practice.

Recent graduates in medicine, in contrast, have been trained to such extent in these institutional accessories to medical practice that they feel almost helpless when suddenly thrown into communities where the facilities are lacking.

* * *

A.M.A.'s Annual Hospital Survey.—The April 20 issue of *Journal of the American Medical Association* is this year's hospital number. The statistical and other informative comment commences on page 1073 and carries through for some 89 following pages. From the excellent hospital survey portrayed in *J.A.M.A.*, these gleanings may be of interest:

During 1945 one patient was admitted to a hospital in the continental United States every 1.9 seconds and a live baby was born in a hospital every 16 seconds, according to the 25th annual report of the Council on Medical Education and Hospitals of the American Medical Association.

F. H. Arestad, M.D., and M. G. Westmoreland, M.D., present the Council report in the April 20 issue of *The Journal of the American Medical Association.* Their figures reveal that in comparison with 1944 the number of hospital beds has increased from 1,729,945 to 1,738,944, the number of admissions from 16,036,848 to 16,257,402, the number of patient days from 475,607,484 to 512,915,155 and the number of hospital births from 1,919,976 to 1,969,667.

Represented in the report are 6,511 hospitals registered by the American Medical Association, including 1,156 hospitals approved for internships and residencies and 2,625 accredited by the American College of Surgeons as meeting unconditionally its minimum requirements for general standardization.

Both governmental and nongovernmental hospitals showed a slight increase in bed capacity last year, the governmental group reporting 1,356,718 or 78 per cent of all beds, the nongovernmental hospitals 382,226 or 22 per cent.

General hospitals supply the greatest volume of hospital service in the United States. Last year they admitted 15,228,270 patients—93.6 per cent of all admissions—and maintained an average daily patient load of 665,105. In addition they gave care to 1,907,772 newborn infants, 96.8 per cent of all live births reported in the registered hospitals in 1945. The nongovernmental general hospitals had a total of 9,371,874 admissions, the federal general hospitals 3,898,995 and the other governmental general hospitals 1,957,401.

The mental hospitals with 37.7 per cent of all beds had 248,876 admissions or only 1.5 per cent of the total patients admitted in 1945. In comparison with 1944 there was an increased number of mental patients admitted in all nongovernmental groups. The mental hospitals under state, county and municipal control showed a slight decrease, but the federal division reported an increase of 13,147. The total gain in relation to the previous year was 22,483.

* * *

State of California Is Making a Survey of Its Hospitals.—Hospital Surveys are now under way in several states. At the recent special session of California's Legislature, upon recommendation of Governor Warren, funds were set aside for a hospital survey in our own State. A press release of April 22nd gives the information in regard thereto:

> Approval of a survey to be conducted by the State Department of Public Health to determine the extent of hospital and health center facilities in California was given by the State Advisory Council on Hospital Facilities at its initial meeting in San Francisco Monday (April 22).
>
> A questionnaire form to be completed by hospital administrators was adopted by the Council. It is expected that by late summer the Council will have available all essential facts necessary for its use in developing a plan to make good hospital facilities available to all the people everywhere in the State.
>
> The survey of hospital facilities will be made under the direction of Dr. P. K. Gilman, Chief of the Bureau of Hospital Surveys, State Department of Public Health. Health center facilities will be surveyed by the staff of the Department's Division of Local Health Service under the direction of Dr. Ellis D. Sox, Chief.

* * *

California's Hospitals for the Mentally Ill.—In California and Western Medicine for April (Vol. 64, No. 4) appeared a statement made by Governor Earl Warren in his March 21 address before the Los Angeles County Medical Association and the U.C.L.A. Alumni Association, that has bearing on the operation of California's hospitals for the mentally ill. Governor Warren there said:

> Not only have we reorganized our California Department of Public Health, we have thoroughly revamped and modernized our old Department of Institutions. This latter is now in name and in fact the Department of Mental Hygiene. I am determined that in the operation of our mental hospitals, we will take California completely out of the "asylum age" and establish our State firmly in the "hospital age."
>
> In the last analysis, it will be cheaper even financially to do this, to say nothing of the human values involved. I am determined that we shall place the emphasis as much as possible on the prevention of mental disorders rather than on mere custodial care. We have made some progress—not enough to be satisfactory, but certainly enough to be stimulating. We have stripped the Department of Mental Hygiene of every extraneous function. Now it is devoting itself exclusively to the prevention and care of mental disease.

* * *

Pertinent to the above may be given an excerpt from a recent paper by Dr. C. Charles Burlingame, president and psychiatrist-in-chief of the Institute of Living in Hartford, Connecticut, one of the oldest psychiatric institutions in the United States, and Connecticut's oldest hospital of any kind. Dr. Burlingame makes this significant comment:

> "As a matter of fact, free enterprise might well question itself as to whether it has shirked its obligations by sloughing off the care of the mentally ill and allowing psychiatry to get into the present-day state of affairs through political medicine."

* * *

Major General Paul R. Hawley's Address at the University of California Medical School Service Men's Dinner.—Before leaving the subject, reference may also be made to an address given by Major General Paul R. Hawley, Surgeon General in charge, Medical Department, United States Veterans' Administration, in San Francisco on April 25th, at the testimonial dinner tendered to service men who are staff members and alumni of the University of California Medical School.

Speaking of V.A. service to veterans, Dr. Hawley stressed the value of placing V.A. hospitals and medical services in close proximity to teaching schools and hospitals. It was Dr. Hawley's opinion, based on his observations when he was Surgeon in Charge in the European War Theatre, that the lower mortality rates of World War II were in no slight degree due to the hospital units that had been sent abroad by America's medical schools. Most of these units had teaching members on their staffs, who had served in their own medical school hospitals, so that new personnel coming into the units through transfers, were rapidly indoctrinated, to become harmonious and efficient members of the respective staffs.

* * *

The evidence concerning the value of modern hospitals in conservation of human health and life is abundant. In every community, where a hospital is in operation, it is to be hoped that the highest standards of service will be emulated, to the end that hospitals everywhere shall become real health centers, both as regards curative and preventive medicine. With the aid of well organized hospitals, scientific medicine will move forward in continued betterment.

GOOD WISHES TO THE NEW EDITORIAL STAFF

The report of your present Editor appeared in the "Pre-Convention Bulletin" on page 210. Mention was made therein that your Editor will give up editorial supervision of CALIFORNIA AND WESTERN MEDICINE with this May issue. Also as there stated, the present Editor has had the great privilege of acting in that capacity since March 19, 1927, a period of twenty years lacking one. It has been a great pleasure to have been permitted to have had the editorial management of the OFFICIAL JOURNAL of the California Medical Association during these two decades.

Your retiring Editor, who will now take up his new duties as Honorary Historian, is under great obligation to the many members of the California Medical Association who have given to him their generous coöperation, and in making his farewell as Editor, he desires again to express his sincere appreciation of their kindly help.

It follows also that the best of wishes are tendered to those whom the Council will place in charge of CALIFORNIA AND WESTERN MEDICINE, and also as always, sincerest good wishes to all members of the California Medical Association.

EDITORIAL COMMENT†

NUTRITIONAL HYPERSUSCEPTIBILITY

A hitherto unsuspected nutritional factor causing hypersusceptibility to experimental pneumococcal infection in mice is described by Hitchings[1] and his associates of the Welcome Research Laboratories, Tuckahoe, N. Y.

The New York investigators maintained groups of white mice on three commercial diets: A, Purine Fox Chow; B, Rocklands mouse diet, and C, Robinson and Siegel's improved stock diet.[2] Before inoculation, certain groups were changed to a synthetic basal diet, consisting of casein, salts, cotton-seed oil, cod liver oil and sucrose, supplemented by thiamin chloride hydrochloride, riboflavin, pyridoxine chloride, calcium pantothenate, nicotinamide, p-aminobenzoic acid, and several other essential food factors.

Five days after this change, each mouse of all groups was injected intraperitoneally with 0.5 cc. of a 10^6 dilution of a 17 hour broth culture of pneumococci. The actual number of organisms injected varied from 235 to 700, as determined by plate count. Of the 56 mice on commercial diet A, 50 died within 6 days, a mortality rate of 89 per cent. The mortality was 60 per cent in the group fed diet B, and 70 per cent with diet C. Among 52 mice on the new synthetic diet, 45 survived, a mortality rate of but 14 per cent.

Even more spectacular results were recorded with mice injected with 10 times the routine test dose of pneumococci. In the group on diet A, all mice were dead by the third day, a mortality rate of 100 per cent. In a parallel test of mice fed for five days on the new synthetic diet, the mortality rate was but 22 per cent.

Hitchings believes that the most satisfactory explanation of the results is the assumption that some unknown factor stimulating the rate of multiplication of pneumococci is present in the commercial diets and absent from the synthetic basal diet. This hypothetical substance would not be essential for the mouse. The substance would be present in minimal concentration in the blood and body fluids except in so far as higher levels are maintained by a more or less continuous supply from exogenous sources. This would explain the rapid loss of nutritional hypersusceptibility when commercially fed mice are changed to the new synthetic diet. Attempts are being continued to identify and isolate this hypothetical bacterial growth stimulant.

A second possible explanation is suggested by the "opposition factor" or "anti-immunity protein" recently described by Day[3] of the Pathological Institute, St. Mary's Hospital, London. This haptin is semi-specific for the pneumococcus, and is found in numerous saprophytic bacteria, presumably in bacterial food contaminants. It is theoretically possible that this non-antigenic bacterial contaminant in commercial foods may cause a continuous depression of normal pneumococcus resistance, or a "blocking" antibody[4] of sufficient titer to cause the observed increased mortality in mice maintained on such commercial diets.

Either suggested possiblity would be of basic clinical interest.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

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2. Robinson, H. J., and Siegel, H., J. Infect. Dis., 75:127, 1944.

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A people [Americans] who are still, as it were, but in the gristle, and not yet hardened into the bone of manhood.

—Edmund Burke, *Conciliation with America.*

I have lived enough, for I die unconquered.

—Epaminonads. (Cornelius Nepos, *Lives: Epaminondas.*)

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

Scientific and General

MEDICINE AND THE PUBLIC*

PHILIP K. GILMAN, M.D.
San Francisco

ONE year ago the then president of this Association, Doctor Lowell S. Goin, delivered as his outgoing address a masterly oration on the philosophy of compulsory health insurance.

Today it is my privilege to supplement his remarks in an effort to tie in with the philosophy of compulsory health insurance the practical aspects—the practical application—of health insurance, particularly as it affects the relationships of the medical profession with the people and their government.

I mention the people and their government advisedly because I fear that too few of us are aware of the influence the people hold over all of us. The great American public is definitely our master and boss—and if we fail to heed that fact we are, sooner or later, headed straight for trouble. The people are the ones who tell us where to practice, how to practice, what fees to charge. The people dictate every one of our actions to us. Their control over our profession is not a direct thing and is often unseen. Individuals do not come and give us orders, but as a group our patients exercise the same restraint and control over us in an indirect manner they might show directly. We are all familiar with the physician, be he internist, surgeon, obstetrician or general practitioner, whose office practice or whose fees are out of line with what the public expects or has been taught to expect. That practitioner eventually falls by the wayside. His patients leave him for someone else and, unless he conforms to the standards set by the public itself, he finds himself a doctor without a practice.

Here in California—and there are many other places where the same is true—the medical profession has learned to a great extent to heed the voice of the people and to increasingly take the people into its confidence. The medical profession has learned to study and work with the public and to lend advice, counsel, leadership and guidance in those fields where the public interest is at stake and where by training and experience medical opinion is better qualified and more pertinent. Where doctors with their specialized background are actually the better judge, it is their obligation to furnish the leadership and guidance which will create better public health conditions. I repeat—here and in some other places—this lesson has been learned.

Those who have followed the progress of public thinking relative to sickness insurance have long been aware that this same public is seeking not something for nothing, but something which people throughout the world have long wished for. The people are seeking security. They want to know that when they go to bed at night they can sleep and not lie awake plagued by worries over unpaid medical and hospital bills or uncared-for illnesses. In the realm of sickness insurance they seek the two-way security of knowing that both their ills and their bills will be taken care of.

If we as physicians are to care for these bodily ills we must also see that the patient's monetary difficulties are adequately handled, that the fear of incurring a debt will not prevent people from seeking our advice and care.

Some of the more astute political leaders have long sensed this demand on the part of the public and have catered to it. Attempts have been made here in California for the past twenty-nine years to impose upon the people, under one guise or another, a system of government-controlled medicine. We know that these attempts have not as yet been successful but we would be burying our heads in the sand if we did not heed the significance of these legislative threats. Instead of ignoring or merely combating these moves we have paid attention to them and, with our own background of training and experience are guiding these efforts into paths which will lead to a better spread of medical care for the people without jeopardizing the quality of such care. The medical profession by becoming more active and forward-looking into its economic as well as its professional aspects is better serving the people.

Unfortunately the efforts and thinking of some legislators on the entire subject of sickness insurance has, to date, been directed solely along economic lines with no regard for the professional status of the doctors who must be called upon to render the professional services. The bureaucrats envision only the picture of a large number of people who by the law of averages will need medical care now or later and who, by the same law of averages, will experience financial hardship in trying to meet the cost of that care. The government planners therefore reduce the entire matter to one of dollars and cents. Thus reduced, medical care becomes a commodity which can be bought and sold for so much—or little—cash. What is left out of the picture entirely is the quality of medical care which would be delivered to the public under such an assembly-line system.

We as physicians must not make the same mistake the proponents of political control have made. We must continue to plan so that the quality of medical care will not suffer in our efforts to increase the quantity of that care.

In exploring this field of prepaid medical care we have followed those lines of thought along which we have all been trained. We have gone cautiously lest the dose prove lethal. We have tested every step, moving from one to another only when we have been sure of our footing on the earlier step. By this process we have discovered many of the underlying weaknesses in insurance plans which may have a popular public appeal, which provide fine sounding campaign material for the politician but which we know would inevitably result in bad medicine for the public. Surely our obligation is to protect the people, not subject them to experiments which may well prove more harmful than good.

One difficulty in this process of evolution rather than revolution in the methods of medical practice is that we have not yet been able to extend our prepayment services to enough of the people. There are still too many who have not been able to take advantage of these services and who are thus more readily influenced by the promises of the compulsory system advocates who seek control rather than better health standards.

Today we have before us the best opportunity we have ever had to increase the spread of our own prepayment service. We have an aroused and militant medical profession spurred on to greater efforts by the knowledge that the planner is lurking in the background, waiting to push his schemes through our legislative bodies. We have in our own prepayment plan—California Physicians' Service—a medically and financially sound business operation. We have the proper personnel to carry out the forms of coverage which our professional actuaries have told us will produce the desired results. We have the experience of seven years of continuous operation under such a wide variety of conditions that we can truthfully say we have seen everything and experienced all possible modifying circumstances.

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* Address of the President. Read before first General Meeting, at the Seventy-fifth Annual Session of the California Medical Association, Los Angeles, May 7-10, 1946.

A further aid to spreading and improving the quality of voluntary medical care is the growing interest on the part of the public in proper facilities where they may receive this care. These facilities constitute the physician's workshop and are the hospitals and health centers which should be the distributing points for all types of medical service—preventive, diagnostic and therapeutic. Ideally, these facilities, in addition to providing restorative care to those disabled by injury or disease, should function not only for the maintenance and improvement of health but for continuing education of doctors, dentists, nurses and related professions. Too, the education of the general public on matters pertaining to health should not be neglected.

A survey of these facilities is now being made in California. Plans will be evolved from this to so coördinate facilities throughout the State as to make them available to all the population. Thus implemented the medical profession will be in an even improved position to render not only its present high standard of care but better care and on a more extensive scale, reaching into areas not at present receiving such services.

Today we must continue to move forward. We must enter into enrollment drives of our California Physicians' Service throughout the State and make sure that every individual who can possibly be covered by voluntary sickness insurance is so covered. We must coöperate with the other voluntary plans and prove to the people and to the legislators that there is no room left for any compulsory scheme which would disrupt the very foundations of scientific medicine.

This is our obligation here at home. But there is an even greater obligation away from home.

Today we see the drive for compulsory sickness insurance transferred from our own State capitol to Washington, where both the Senate and the House of Representatives have bills before them to set up a nationwide system of Federally-controlled and Federally-operated medical care. We know that the pitfalls of a nationwide system are just so much more serious than those in a system confined to a single state.

We may meet among ourselves and tell each other that the national demand for compulsory medical care is not the same as a state demand, that health conditions in Mississippi or New Hampshire are not the same as in California. We may blind ourselves to the fact that the national Congress must view the whole nationwide scene and enact legislation which crosses over state lines and ignores the situation in one state in order to favor a different situation in another.

If we do take a full look at the national scene we are bound to admit that some of the arguments for compulsory sickness insurance must be given credence insofar as some sections of the country are concerned. We may have a different situation here at home but we are all aware of the poor health conditions which prevail in some areas which are seized upon by some Congressmen as indicative of similar poor standards throughout the land.

And again—we have a solution in our grasp. We have the power and the authority to lend our own experience and our accumulated knowledge to other states. We have the obligation to do so and only by doing this may we hope to achieve in other states and thus in a nationwide way the same standards of availability of prepayment medical care that we are accustomed to in our own State.

Several years back we began hearing of Congressmen who were labeled as isolationists. These were the men who supposedly wished to ignore world conditions and concentrate their entire thinking on our own internal problems. We in medicine must not make that same mistake or we will put ourselves and the future of medicine squarely in the path of conditions originating outside our own State borders and affecting us along with the rest of the country.

In the past year we have been able to extend a helping hand to some of our sister states. We have been able and willing to send some of our own men, men of experience and training, into these states and assist the physicians there to establish prepayment plans of their own, designed to meet local conditions. At least three of the western states have welcomed our representatives and several others have started an inquiry which undoubtedly will lead to the same sort of action in those states.

I mention this not in any paternalistic mood but simply as an example of the need of sharing our economic knowledge as well as our scientific findings. Surely if we accept the principle of passing along to our colleagues any advances in medical science which come our way, we should be similarly willing to share our economic advances.

Not only have the doctors of California been able and willing to meet with their neighboring states in this movement but they have gone a full step forward in proposing national action along the same lines. The recent announcement by the American Medical Association of the formation of a federation of state medical prepayment plans represents the tangible development of a pattern of coöperative effort which was drawn up in California and which met with instant response when presented at the A.M.A. meeting. Under this program, the twenty-five states which now have prepayment medical care plans in operation will have a central meeting place, a clearing house if you will, for the interchange of information, for the making of reciprocal agreements between states and for the standardization of benefits on a nationwide basis. Further, these plans will collect in one place all the accumulated experience from twenty-five states and will make this information and experience available to those twenty-three states which are not now operating prepayment plans of their own.

With this sort of a foundation we can look forward confidently to the day when every state in the union will offer to its citizens a prepayment medical care program which will be honored not only at home but in any state. When that day comes we may look for a cessation of the attacks upon our profession by the bureaucrats who have sensed this public desire and have hit upon their own schemes for meeting it, regardless of the effect upon the quality of medical care the public would receive.

These statements may seem as though I am speaking from behind rose-colored glasses. They may seem too much on the optimistic side. If this is the case, we are all in for a long and bitter struggle if we are to preserve medical practice in this country in its present state of excellence.

These threats to our state and national programs have consolidated the medical profession to an extent never before realized. With complete unity of effort there is little or nothing we may not accomplish, no inroads we may not combat. While some of our members have lagged behind others in accepting new ideas and many, on account of the demands of the recent emergency, have lacked time to keep abreast of the developments that have taken place in our organization we are today united as never before behind plans to preserve the practice of medicine on a voluntary basis.

Gone by is the period in our progress during which those who had ideas of their own and who for reasons best known to themselves sought to give aid and comfort to the politically-minded legislative planners and only lip service or even less in support of our efforts to provide a prepayment budget system for the great middle class of the people. The vast structure which our pioneers have built up in this field of medical care is now on a firm foundation. It is an accomplishment of which we may all be proud and no longer merits any but wholehearted and enthusiastic support of our entire membership as well as the devoted and meticulous rendering under it of professional services by each and every one of us.

Today we have proved in California that our great middle-income group of citizens can be provided with superior medical care under a budget system of payment. We have proved that government is not needed as a middleman to insure the delivery of this service. We have proved that the physicians themselves can operate their own business of meeting the economic as well as the medical needs of their patients. We have proved that the public can be served when the physicians actually achieve the desire to serve.

Evidence of this is mounting as we extend our services to an increasingly large percentage of the public and our problems appear to be correspondingly nearer of solution. We have accepted the responsibility of public service which the public itself has placed upon us.

We have all seen the statement made repeatedly that the public is divided into three categories—the rich, the middle-income group and the indigent. Likewise, we have heard it said many times the rich and the indigent receive the best in medical care while the middle-income group fail to receive this care because of the lack of funds with which to pay for it. We as physicians are now not only willing to accept fees from the well-to-do and provide service free to the indigent, but are united and similarly willing to provide a prepayment service to that great group of middle-income citizens between these two extremes.

Possibly those among us who have sons or daughters either practicing or preparing to practice medicine are more keenly aware of the medico-economic problems not as yet completely solved. One of the fundamental reasons why American medicine has become so outstanding is that we doctors as a group throughout the nation have been willing to share our scientific knowledge freely with our fellows. This stimulating exchange of systematic thought has contributed largely to our present-day standards of medical practice. We parents want to make sure our children receive every possible benefit of our own accumulated professional experience so that they will be enabled to start in where we leave off. If not only those with doctor sons and daughters, but all in our ranks would apply this same principle of sharing of ideas and experience on the economic side of our profession, the lengths to which our calling could develop are without limit.

In leaving office as president of this Association, I wish to impress upon you this thought: medicine has obligations as well as privileges and unless we continue to meet those obligations our profession will cease to make the splendid progress which it is now showing. As there is no standing still, failure to continue our forward march will inevitably result in regression. From this it would take a long period of time to recover.

On the other hand if each one of us continues to do his part and if each of us keeps on performing in the true spirit of public service, the years ahead will see unlimited achievements in medical practice and in the health of our common master, the public.

Room 423, at 760 Market Street.

American life storms about us daily, and is slow to find a tongue.

—Emerson, *Letters and Social Aims: Poetry and Imagination.*

The good man should not live as long as it pleases him, but as long as he ought.

—Seneca, *Epistulae ad Lucilium.* Epis, civ, 3.

DOES THE PUBLIC WANT HEALTH?*

George M. Uhl, M. D.
Los Angeles

It is a frequent occurrence for a health officer to receive letters from the public he serves. Consideration of these communications is of value as it frequently is a means of interpreting trends in public opinion. Many of the letters, in the nature of complaints, are groundless and must be ignored as they represent personal grievances only. Others are sufficiently sound to command attention and inspire action. Such a letter was recently received. It was in the form of a simple and rather embarrassing question:

"Why, when the method of preventing diphtheria is so well known and accepted, do cases and deaths still occur?"

Upon first thought it might appear simple to answer this question. One might philosophize and satisfy his ego by pointing out that actually there are relatively few diphtheria cases and deaths compared to those that occurred a few years ago. It might be pointed out that true perfection in anything rarely occurs and that we normally should expect a few "exceptions to the rule." Yet, the question is not answered.

It has deeper implications. It applies not only to diphtheria, but to other preventable diseases. We still have smallpox, whooping cough, tuberculosis, and the venereal diseases. They are all preventable, yet they still plague our populace. Why?

There has certainly been no lack of interest recently in the whole medical program. State and federal legislation has been proposed which calls for radical changes. But would such changes answer the question? Most of the proposed legislation is based on the premise that our medical program is deficient because it is either inadequate or unavailable to all.

Let us, just for the purpose of discussion, assume that we did have a medical-care program which was completely adequate and freely available to all. Would preventable diseases vanish and would all persons immediately be provided with the medical care that they might need? I am certain that the answer of men who have worked in the public health field would be in the negative.

* * *

Many examples may be cited to account for this pessimistic attitude. For years health departments have been conducting free pre-natal and well-baby conferences for needy individuals. Do all persons who are eligible attend regularly and receive their benefits? Unfortunately they do not and usually those who are in greatest need never appear.

Some time ago one of the larger health departments in the state offered free annual physical examinations to all its employees. It was suggested that each employee make an appointment to have the examination either on or very near to his birthday, as this would facilitate his remembering it. About 1 per cent of the employees of the department took advantage of the opportunity. The program has been discontinued due to lack of interest.

For many years immunization against diphtheria and vaccination against smallpox has been offered in many of our public schools at no cost to the individual. Have we had 100 per cent acceptance? Unfortunately, we have not.

Tuberculosis has received great publicity in recent years. The cause and methods of prevention and cure are well known. Diagnostic clinics and treatment are available to all, yet a recent survey in the City of Los Angeles revealed that only 16.8 per cent of cases reported were in the minimal stage and 83.2 per cent of cases reported were either moderately or far advanced.

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* Chairman's Address. Given before the Section on Public Health at the Seventy-fifth Annual Session of the California Medical Association, Los Angeles, May 7-10, 1946.

It is now accepted that cancer is curable if discovered in the early stages. The death rate from this disease, however, clearly indicates that cases are not being seen early. Competent physicians are available in most areas to diagnose and treat cancer. Yet, all too frequently, the patient consults his physician too late.

* * *

Among the most unpopular responsibilities of a health officer are the isolation of communicable diseases and the maintenance of sanitary conditions in public places. The action of the quarantine officer is resented, because it interferes with personal liberties. The individual affected seldom considers the fact that his own predicament is the result of some other person's carelessness or negligence in failing to observe isolation precautions. Instances have even occurred where the sufferer from a contagious disease has knowingly exposed others, foolishly feeling that he was "getting even."

Sanitary inspectors too frequently meet with resistance when they insist on scrupulous cleanliness in public eating establishments and proper sterilization of glassware, dishes, and utensils. This occurs in the face of the known fact that one serving of contaminated food may not only cause severe illness and even death, but may also put the responsible food establishment out of business.

Why do we experience this resistance from the public against those things that are known to be of benefit? Why do so many individuals present themselves for medical care only as a last resort? Is it because we are a nation of individualists who believe that disease is a misfortune that strikes only the other fellow? Is it because we are basically gamblers who are willing to take our chances with fate and, so long as we are well today, not worry about what may happen tomorrow? Or, is it because we placate ourselves by believing that we are health conscious and stoically observe all sound health principles and teachings except those which cause us inconvenience or interfere with our personal pleasures.

* * *

Some time ago we had a rather interesting experience in our health department which may give us a lead to the solution of our problem. Following the onset of war we were confronted with a sudden and overwhelming increase in population. Housing conditions reached a deplorable state due to overcrowding. Our inspectors reported intolerable conditions existing in our eating places due both to lack of sufficient help and to the demand for feeding an increased number of persons. Customary methods of enforcement of sanitary regulations failed entirely to remedy the situation. In desperation the department adopted the policy of citing offenders directly to court where fines and jail sentences were imposed. Conditions improved rapidly but there was vociferous resentment on the part of those who suffered the indignity of being haled into court. A meeting was held with representatives of the industries involved. To our surprise, after the dangers of insanitation were explained and the requirements of the health department outlined, the representatives expressed themselves as more than willing to remedy the situation. Lack of knowledge was largely responsible for the existence of the hazardous conditions. Following the meeting, courses of training for food handlers were established. These courses had the full support of the industry and were surprisingly well attended. Today our coöperation with the industry is excellent and very few court citations need to be issued.

* * *

What has been learned in the field of sanitation may well be applied to the field of medicine. In fact the evolution of modern public health practices had its birth in the cleaning up of the environment. The development of public knowledge and acceptance of the advantages and opportunities of modern medicine had not kept pace with the development of the science.

Within recent years there has been nation-wide publicity and the collection of millions of dollars to combat poliomyelitis. Huge sums have been and are now being spent for research to find the cause and a reliable method of preventing the disease. But, should such a preventive agent be discovered, would it be universally used and would poliomyelitis vanish? If we judge by our experience with diphtheria, we must hang our heads and admit that it would not.

* * *

Considering the facts which have been presented, we must be honest with ourselves and admit our failure in one phase of the field of medicine and public health. We have failed to develop and promote the public intellect sufficiently to demand and accept the medical benefits which are available to them.

Before we can ever realize the goal of a nation free from preventable diseases, we must expand greatly in the field of health education. The old adage about leading the horse to water, but not making him drink, is trite, but still basically sound and appropriate in this instance. Our populace will enjoy sound health only when it wants to and knows how to.

* * *

The expenditure of huge sums of governmental funds to provide more hospitals, more health centers, and more doctors is not sufficient. A program must be developed which will inculcate into the very roots of each individual the sound knowledge of the desire for adequate medical care.

Such a program must be developed intelligently. It must be designed to teach the individual self-reliance and promote initiative. Too frequently in the past our programs have been designed only to provide services for the public. We have failed to make our services attractive, and desirable. The very nature of certain medical procedures is such as to cause apprehension. This fear must be dispelled by a sound and logical presentation of facts. It is quite true that a smallpox vaccination produces physical discomfort, yet the discomfort is infinitesimal when compared with the suffering that results from the disease.

* * *

Two years ago we were confronted in Los Angeles with a sudden increase in diphtheria cases and deaths. To combat this increase, a concentrated immunization campaign was organized. Newspaper articles, short radio "plugs," posters, and talks before civic groups were all utilized in the campaign. In addition, a consent slip, on which was printed a statement outlining the nature, cause, and method of preventing the disease, was distributed to school children and to our clinic patrons. Private physicians coöperated in the campaign by stressing to their patients the importance of diphtheria prevention. The result? Immunizations in the public schools increased by 50 per cent; immunizations in our own clinics increased 100 per cent and practicing physicians reported that they were swamped by requests for diphtheria protection. Following the campaign there was a sharp drop in the incidence of diphtheria which has continued to date.

The above experience is cited as a small-scale example of what can be accomplished through health education. It is intriguing to speculate on what might be the result of a large-scale, nation-wide campaign devoted to sound health education.

* * *

We have just emerged from a war for which we mobilized 13 million men into one of the finest fighting organizations the world has ever known. We have never lost a war to mortal enemies, even though we have at times been slow at the start. We can also be victorious in our war against disease if we, as a nation, will to do so. We have not, however, really mustered our full potential strength for a crushing blow. Such a mobilization will require expert leadership and hard work. It is up to the medical profession, in all of its branches, to provide that leadership lest it be taken up by those less qualified to do so.

* * *

We can now answer the question as to why we still suffer from preventable disease. We suffer because we have never fully used all of the resources that are at our command. If we will but apply all of the known means for disease prevention we'll awaken one day to find that our common enemy has been vanquished. Then, and then only, will be have a nation free from preventable disease, which is a worthy goal and our rightful heritage.

116 Temple Street.

PROTEIN NEEDS OF THE AGED SURGICAL PATIENT*

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PREVAILING concepts of the nutritional needs of the surgical patient have undergone revolutionary change over the past decades. It is not a far cry to the day when water was systematically withheld from the patient for twelve to eighteen hours before operation, and usually for one or more days following operation. Furthermore, a postoperative period of starvation was considered scientific and viewed with complacency. Today every surgeon is conscious of the dynamic significance of water balance, the necessity of maintaining the caloric and electrolite needs of the patient, and the place of the vitamins in assuring functional equilibrium.

The most recent contribution of biochemistry to the field of nutrition has concerned the protein substances. Indeed during the past few years a vast literature has developed in the field of protein metabolism, a subject which seems destined to assume a rôle of major importance in the entire field of medical practice.

If protein deficiencies are of common occurrence, there are special reasons why patients of advanced age should be prone to develop such deficits. It is therefore a subject which should engage the serious attention of the urologist, whose efforts are largely devoted to the surgery of geriatrics. The implications of the problem are far reaching and very complex. In this discourse we can only touch upon bare essentials, stressing particularly the more practical aspects of the subject.

THE NATURE OF PROTEINS AND THEIR USES

Proteins are the structural units of body tissues, and in turn the building blocks of proteins are the amino acids. The structure and properties of more than 40 amino acids have been identified, 22 of these being important to the body economy. Of the latter group 10 are classified as "essential amino acids," indicating that they are necessary for some essential physiological process. In fact the omission of any one of these essential amino acids is inimical to growth and life. Furthermore, the essential amino acids are exceptional in that they cannot be fabricated by the body in sufficient amounts to satisfy its needs, hence they must be obtained ready made from the food ingested.

When protein food is taken by mouth its complex molecules are broken down by the proteolytic enzymes of digestion into simple diffusible compounds. The action of pepsin in the stomach hydrolyzes the molecule into proteoses and peptones. In the intestines these are further degraded into free amino acids, whence they enter the portal and general circulation. A certain portion of these circulating amino acids, depending upon the nutritional state of the individual, will be used to build new tissues and to augment the body stores of protein; the balance will be deaminated by the liver with the production of carbohydrate and non-protein nitrogen. The carbohydrate fraction contributes to the energy requirements of the body, while the non-protein nitrogen is eliminated in the urine. In caloric value a gram of protein is essentially equivalent to a gram of carbohydrate.

The minimal protein requirements of an individual is that amount necessary to keep him in nitrogen balance. This state exists when the nitrogen intake equals the nitrogen excreted. During a state of negative nitrogen balance the excretion of nitrogen is greater than the amount consumed. Barring an inability on the part of the individual to absorb proteins, this would mean either an inadequate ingestion or an increased breakdown of body proteins. The optimal diet should provide protein much in excess of the amount which is barely capable of maintaining nitrogen balance. A daily intake of one gram of protein per kilogram of body weight is considered an adequate daily ration for an average person.

Elman[1] has recently emphasized that all protein within the body is in a constant state of chemical activity, and that the older concept of great masses of inactive protein stores is untenable. A dynamic equilibrium exists between the blood proteins and the tissue proteins. It is essential that the circulating proteins in the blood stream are held at a fairly constant level, and the body proteins will make every sacrifice to maintain this blood level. The same author[2] has determined that a reduction of one gram in the total circulating plasma albumin indicates a loss of 30 grams of body protein. On the basis of these calculations, a reduction of no more than one-half grams per cent in the plasma albumin of a patient with normal blood volume could represent a loss of over 500 grams of albumin from the body. It is thus evident that any appreciable drop in the concentration of the serum albumin implies an impending exhaustion of body protein.

The circulating proteins are of two distinct groups, the albumin and the globulins. The latter group has been fractionated into fibrinogen and the alpha, beta and gamma globulins. Most authorities state the normal concentrations of these two groups as being from 4.0 to 5.5 gm. per 100 cc. for plasma albumin, from 1.5 to 3.0 gm. per 100 cc. for globulin, and the total plasma proteins running from 6.0 to 8.0 gm. per 100 cc. In instances of protein deficiency the plasma albumin is the chief variant. The globulins are less apt to drop below their norm; in fact they may be elevated at a time when total proteins are low, particularly during periods of sepsis and fever. Patients presenting total plasma proteins below 3 gms. per cent practically always succumb. The lowest concentrations which we personally have observed were in a chronic alcoholic with cirrhosis of the liver, in whom the blood levels shortly before death registered serum albumin 1.8 gm. per cent and the globulin 1.0 gm. per cent.

Aside from the fact that proteins are the chief component of muscles and all glandular structures, their various uses within the body are seemingly manifold. They control the distribution of the body fluids; they maintain the nourishing properties of the blood cells; they act as conveyors in the blood stream of many essential materials, such as calcium; they contribute largely to the body's defense mechanisms; they are important constituents of both enzymes and hormones; and they probably act as catalysts without which the vitamins are ineffective.

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* Chairman's Address. Read before the Section on Urology at the Seventy-fifth Annual Session of the California Medical Association, Los Angeles, May 7-10, 1946.

Special emphasis should be given to the position of proteins in the control of water balance. The plasma proteins are immense colloid molecules which supply the principal intravascular osmotic force. By comparison a molecule of serum albumin weighs a thousand times more than a molecule of glucose. They thus exert a tremendous pull upon the intercellular fluids, drawing water into the capillaries and also checking its escape. In the presence of protein deficiency states, the tug of the tissue fluids is able to reverse the direction of flow, with a resultant clinical edema, a condition commonly observed in many of the starved races of Europe today.

There are many factors which contribute to protein deficiency. By and large, it is usually due to one or more of the following conditions: 1. An insufficient protein intake; 2. An inability on the part of the organism to properly digest and absorb proteins; 3. An inadequate synthesis of plasma proteins by the liver; and 4. An excessive loss of proteins.

THE AGED PATIENT

As man advances in age he becomes sedentary, expends less energy, and his need of caloric food diminishes. Contrarily, the dynamic nitrogen exchange within his body continues unabated throughout life, and sufficient proteins should be supplied to satisfy these processes. A person in this age group frequently suffers with protracted and debilitating diseases which predispose him to nutritional disorders. Let us examine the elderly patient in the light of the above enumerated causes of protein deficiency.

The aged patient is apt to be a refractory patient. His mental pattern is often characterized by cantankerous obstinacy and with fixed ideas as to what is good for him. His defective teeth make mastication of solid food difficult. Achlorhydria, which is present in over 40 per cent of persons 60 years of age, does not permit a complete breakdown of protein food and further retards pepsin digestion. Thus he has learned that meat, cheese and vegetable proteins "hang like a ball of lead in his stomach," and he has long since discarded them in favor of milk, soups and soft dishes. His chronic constipation may in itself be a cause of anorhexia. It is thus apparent that the dietary of elderly people may be seriously lacking in the complete proteins which supply the essential amino acids, and which are at the same time a rich source of the B complex vitamins.

Sclerosis of tissue is one of the determinants of age. Visceral sclerosis bespeaks reduced functional capacity. In this issue it is pertinent as it relates to the liver and kidneys.

It is now generally accepted that the liver is the main site of albumin formation. Fibrinogen is wholly synthesized here, and possibly the other globulins also. Cirrhosis of the liver is consistently accompanied by alterations in the concentration of plasma albumin. Patch and Post,[3] in studying a group of cirrhotics found that 96 per cent of the cases had albumin concentrations below 4 gm. per 100 cc. Since hypoproteinemia may be present irrespective of edema and ascites, it is assumed that the deficiency is due to an impairment in the liver's ability to synthesize these proteins from the food ingested. Autopsy studies reveal that the incidence of liver cirrhosis reaches its peak in the sixth decade of life. It would seem that in elderly patients even lesser degrees of liver damage may be reflected in the lowered concentration of their blood proteins.

Old age is the season when man is prone to be afflicted by two abnormal mechanical forces which are conducive to renal damage These forces are arterial hyptertension and the obstructive uropathies. Kidney disease is often manifest by the presence of albumin in the urine. The urologist has but to reflect upon the frequency with which varying amounts of albumin are found in residual bladder urine. Urinary protein loss up to one gram per day is probably of no significance. However, Peters and Van Slyke[4] have estimated that a loss of 10 to 20 grams of albumin per day in a 70 kilogram man would reduce the total amount of circulating albumin by nearly one-half in from 4 to 7 days, assuming no replacement to have taken place.

It is not uncommon for obstructive lesions at the bladder neck to be accompanied by bleeding, which if chronic and prolonged may precipitate hypoproteinemia as well as anemia, especially if the protein reserves are low. This provides a further avenue for the abnormal loss of proteins.

A summation of these considerations would indicate that the person of advanced years is inordinately susceptible to all four of the recognized causes of protein deficiency.

PROTEIN DEFICIENCY AND SURGERY

When the aged and ill nourished patient is subjected to surgery he encounters further hazards, since the ordeal of an operation may superimpose an acute hypoproteinemia upon a chronic state of depleted body stores. Protein losses attendant upon surgery may derive from the operation itself or from the exigencies of the postoperative period.

Anesthesia is the first factor to take its toll of the blood proteins. Nitrous oxide, ether and chloroform all cause an increased output of urinary nitrogen, evidencing an increase in the breakdown of tissue protein. Furthermore, the same agents have a depressant effect on liver function which retards the synthesis of the blood proteins. Casten and associates[5] in studying 215 patients receiving various types of surgery, found that 69 per cent showed a drop of 0.5 gm. per cent or more in the blood proteins immediately following operation. If the operation time was under one hour 50 to 60 per cent of the cases showed a drop; if the time consumed exceeded two hours a marked reduction was present in every instance, and apparently the type of anesthesia was of no significance.

Blood loss during operation is usually not an important cause in protein depletion except in instances where the reserves are low, when it may be a significant factor in hypoproteinemia. Surgical shock, which is characterized by a markedly reduced blood volume, can produce an escape of proteins through the transudates, particularly when as the result of chronic toxic infection the capillary walls have been rendered more permeable.

The postoperative days are especially ominous for the ill nourished patient, due chiefly to the almost universal state of relative starvation which exists for a varying period following operation. This may be in accordance with the doctor's orders, or self-imposed. Most patients have a scant appetite for food during the first postoperative days, and in some cases this may become protracted. Anorhexia may be further induced by over-sedation, particularly by narcotics. In the usual ward regimen sufficient glucose and salt solution is given to supply these demands, but there is frequently a total disregard for the need of replenishing the more basic requirement of protein. Where dehydration is not suspected patients seldom receive more than two infusions daily of 5 per cent glucose in salt solution. Yet the carbohydrate supplied in these injections yields only 400 calories, which is far below energy requirements, and the balance will be partially supplied by body proteins.

Elman[6] has vigorously stressed the dangers of postoperative starvation, discussing in detail their effects. One of the principal objective effects is loss of weight, which Elman found to be universal. If all patients were weighed at regular intervals following operation, the loss would at times prove surprisingly great. However, weight loss is intimately related to body fluids, which may be in a state of flux. Even in the absence of demonstrable edema, an increase in extracellular fluids as the result of hypoproteinemia may maintain or even increase the body weight, leading to a false estimate of the patient's condition.

Where water balance is maintained, weight loss means actual loss of body tissue, consisting of both fat and protein structures. Protein loss may be measured by the increased nitrogen excretion. Actual studies[6] have shown that after operation as much as 20 to 40 grams of nitrogen may be excreted per day, which represents from one and one-half to three pounds of body proteins.

During convalescence the symptoms of fatigability and muscular weakness are often observed in patients. Experimentally when healthy young adults were given a diet complete in all elements except protein, there developed after 48 hours severe symptoms of lassitude and asthenia which were corrected rapidly by the ingestion of protein food. Co Tui[7] and his co-workers have shown by tracings with the ergograph that the muscular efficiency of postoperative patients is directly related to protein balance.

A further serious result of deficient protein intake relates to the body defense against infection. Normal defense consists of both natural and acquired immunity. The former is manifest through the process of phagocytosis, while the latter is represented by the mechanism of antibody formation. These forces working in conjunction tend to localize and overwhelm invading organisms. Cannon[8] states that a prolonged period of protein deficiency leads eventually to a marked atrophy of the liver, spleen, bone marrow and lymphoid tissues, and from these tissues most of the phagocytic cells originate. Pathogenic bacteria within the body are foreign proteins which incite specific antibodies. Cannon further asserts that an antibody is but a specifically modified molecule of normal globulin, which must be synthesized from amino acids present in the food or available in the protein reserves. Thus the mechanism of antibody formation resides in the blood globulins, particularly the gamma fraction. Whipple and his group have shown that the fabrication of normal serum globulin is directly dependent upon diet. Cannon[9] has demonstrated that in protein deficient animals antibody production is but one-eighth to one-fifth as great as in those animals on a normal diet.

While severe protein deficiency in urological surgery may not be so dramatic nor so frequently encountered as in certain other conditions, such as severe trauma, burns and gastro-intestinal pathology, nevertheless it is apparent from the foregoing that it is an ever present menace that should be anticipated and corrected. Any survey of mortality records in urological surgery will find high on the list as the cause of death, sepsis and pulmonary edema with terminal pneumonia. It would be of value to know what percentage of these deaths were influenced by hypoproteinemia, resulting in visceral edema and a breakdown in the body defense against infection.

ESTIMATION OF PROTEIN DEFICIENCY

An attempt to evaluate the state of a patient's protein nutrition is difficult, and the evidence of deficiency must often be based on deduction rather than observation. No test exists which will measure the reserve of body proteins. The most valuable information is derived from a study of nitrogen balance, but since this involves measurement of all nitrogen excreted, including that in the urine, feces, vomitus, wound drainage, etc., it is tedious, time consuming and as a routine procedure it is highly impractical.

The most useful laboratory aid in the detection of protein deficiency is the determination of the level of the blood proteins. Indeed, a low level of plasma protein is in itself usually diagnostic of protein deficiency. However, when these levels are within normal limits their significance may be very misleading, since as previously stated, the plasma proteins are maintained at the expense of the tissue proteins, and they may at times mask a dangerous depletion of the body reserves. Plasma determinations must also be considered with relation to the patient's total blood volume. During a state of dehydration the concentrated blood may yield high protein levels, even in the presence of actual hypoproteinemia.

We have conducted studies on the plasma protein levels in 36 consecutive patients who were admitted for prostatic surgery. The youngest patient in this series was 57 and the eldest was 88, the mean age being 71 years. This was a run-of-the-mill group of prostatics with the usual infirmities of senescence, but none presented unusual complications and there were no deaths in the series. The survey was conducted to satisfy our minds as to the practical value of blood protein studies in an age group that should be particularly vulnerable to dietary deficiencies. Total blood volumes were determined with the hematocrit. Among these 36 patients only three showed levels beneath the accepted standard for low normals. Nine other patients gave strong presumptive evidence of depleted protein reserves, yet their plasma albumin and total circulating proteins were normal.

These findings are in keeping with the work of Co Tui,[7] et al, who conducted studies in nitrogen balance on 19 carefully controlled cases of gastric resection. These patients showed a consistent nitrogen deficit, but no corresponding change in the level of the plasma proteins. One should be cautious about placing too great dependence upon blood protein determinations alone. Like many laboratory procedures, a positive test may be diagnostic where a negative test is of little value.

Nutritional edema is an objective sign of hypoproteinemia, but it occurs only in patients with seriously advanced protein depletion. It differs in no essential from other types of edema, and cardiac and renal causes must be eliminated before it can be ascribed to protein exhaustion.

Much information may be obtained from the patient's history that would cause one to suspect actual or impending protein deficiency. Careful inquiry should be made concerning the dietary habits of the individual, the length of his illness and the loss of weight before operation. The latter is of especial concern. A patient who has sustained a marked loss of body substance is almost certain to have depleted his reserves of protein. Studley[10] found that postoperative mortality tends to parallel preoperative weight loss. In studying a group of peptic ulcer patients, he found that in those cases where the preoperative loss had been more than 20 per cent of their normal weight there was a postoperative mortality of 30 per cent. Also in several of these patients there was wound disruption and terminal pneumonia.

In one of our patients who had lost 45 pounds in 90 days as the result of an obstructed pyonephrosis the plasma albumin had dropped to 2.9 gm. per cent and the globulin was normal at 2.0 gm. per cent. This ratio is not infrequently seen, and probably reflects a desperate attempt on the part of the organism to maintain antibody formation at a high level in the presence of a virulent infection.

TREATMENT OF PROTEIN DEFICIENCY

The treatment of protein deficiency will be dealt with briefly, since it varies with etiology and excellent articles on the subject are to be found in the recent literature. Throughout this discussion we have had chiefly in mind the aged patient who is confronted with surgery of the prostate. Many of these individuals are suffering with chronic protein deficiency, which relates to a depletion of their tissue proteins, rather than acute deficiency wherein the plasma proteins have reached low levels. The latter condition is fortunately not so frequently encountered in urological conditions as in some other surgical diseases, notably those requiring gastro-intestinal surgery. However, when surgical shock or hemorrhage are responsible for rapid losses, acute hypoproteinemia may require emergency treatment.

The best time to treat protein deficiency is before the body stores have reached low ebb. Many prostatic patients suffer from cardiac, renal or other infirmities which make advisable a period of pre-operative preparation. This is the time to seek out and correct deficiency in proteins. The matter ranks in importance with stabilization of renal function and the correction of dehydration, which is intimately related to protein metabolism.

When patients preparing for surgery have an aversion for food, have lost weight and exhibit muscular weakness, or reveal evidence of liver damage, the surgeon should immediately institute measures to increase the nitrogen intake regardless of the level of plasma proteins. Protein foods by mouth should be given in excess of the usual gram per kilo formula for daily maintenance. Meats, eggs, milk products, whole grain cereals and the protein vegetables are the richest source of the essential amino acids. Sufficient carbohydrate for energy should be given in order to spare the protein for its more essential function. Fats should be reduced to a minimum in the interest of the liver. If forced feeding of such foods is not tolerated because of anorhexia or gastric upsets, the diet may be supplemented with either powdered skimmed milk or one of the protein digests. The latter are protein rich foods which by hydrolysis have been reduced to their constituent amino acids. They are palatable and easily assimilated by the system, but when they constitute an essential part of the protein intake, adequate vitamins must also be supplied.

When as the result of severe blood loss or surgical shock an acute hypoproteinemia develops, the situation may become critical. Here the problem confronting the surgeon is threefold: to replace the lost blood proteins, to raise the colloidal osmotic pressure within the vessels and to restore normal blood volume with suitable fluids. Treatment is by the intravenous route and should consist of whole blood, blood plasma, plasma albumin and the amino acids.

Considerable divergence of opinion exists as to the relative merits of whole blood, plasma and plasma albumin. The latter is now available commercially and will probably be in demand, since it exerts five times more pull upon the tissue fluids than does plasma. It is claimed that 20 cc. of a 25 per cent solution of albumin will pull three and one-half times its volume into the blood vessels within fifteen minutes. The high cost of both plasma and albumin is an objection to their prolonged use. Blood plasma, while life saving in emergencies, is a poor source of protein nutrition, since two infusions of 500 cc. daily yields only 35 grams of serum protein, an amount far below minimum requirements. Karl Meyer[11] found a combination of whole blood and amino acids best suited to the treatment of acute deficiencies, notwithstanding the fact that the addition of blood cells, temporarily at least, increases hemoconcentration.

Amino acids may be added to the usual infusions of dextrose. When slowly given the body can assimilate from 10 to 20 grams of protein per hour by this route. The production of pure amino acids in crystaline form marks a great advance in protein therapy, since they are non-toxic and they are adequate as the sole source of nitrogen in human nutrition.

When as the result of shock and acute hypoproteinemia the intravascular osmotic pressure is reduced, fluids by the intravenous route should not be given indiscriminately, since over-hydration may induce pulmonary edema. Restoration of blood volume can be determined with the hematocrit, but the most convincing evidence that the blood proteins are replenished and a satisfactory circulation established is to be observed when the patient is again secreting urine in normal volume and concentration.

Over the past year we have used protein digests liberally as a supplement to a high protein, high carbohydrate and low fat diet. All elderly patients being prepared for surgery who have shown evidence of protein malnutrition have been given from 50 to 70 grams of protein hydrolysates by mouth daily, and this dosage has been continued throughout the postoperative period and until the patient has regained body strength and vigor. We have yet to find an individual who has refused the amino acids in this form, even during periods when sufficient water has been difficult to administer.

While there is no means of accurately calibrating the effects of such enforced protein intake, we are definitely convinced that the results are most worthwhile. Patients withstand operation in better condition and the postoperative period of starvation is practically eliminated. Lassitude and muscular weakness are not so commonly observed, and patients are able to leave their beds and resume their usual physical activities in a much shorter period of time.

SUMMARY

Food means life. Many elderly patients requiring surgery are grossly ill-nourished. Regressive senile changes have so lowered the threshold of physiologic activity that the system is at times incapable of synthesizing the essential protein needs from the food ingested. Surgical procedures depress still further a sluggish metabolism and lay waste to already impoverished stores of tissue proteins.

Means are available for evaluating protein requirements and for supplying emergency deficiencies. If the surgeon will but apply this knowledge in his care of the aged individual, not only will the latitude of operability be enhanced, but the patient will be carried through the ordeal of surgery in greater comfort and with an appreciably lessened period of morbidity.

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ACUTE PULMONARY EDEMA*

REPORT OF CASE

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As yet the exact nature of all the physiological processes producing acute pulmonary edema are not known. Cardiac failure seems to be the most prominent immediate cause. Edema may be initiated by diseases of the central nervous system, angioneurotic edema, or by infectous or toxic conditions. There seems to be a factor associated with distention of abdominal organs or disturbance of the pressure of abdominal contents. Pulmonary edema has been reported during and following delivery and the author has seen one case with fatal termination occurring thirty minutes post-partum, in addition to the case to be reported.

The edema fluid is a transudate into the alveoli which causes anoxemia and leads to the clinical signs of cyanosis, tachycardia and shock. Rales are heard on examination. The rapidity of the process and the promptness of the diagnosis and treatment usually determines the ultimate outcome.

Treatment consists of removing the fluid and preventing its formation. Fluid is best removed by intratracheal suction or suction through a bronchoscope. Preventing the formation of more edema may not be possible but if the edema is diagnosed early, there are two of three means which may be used. The first is to increase the osmotic pressure by the use of 50 per cent glucose intravenously. If the edema is due to cardiac failure, this method should not be used since it increases the circulating volume. Instead, the second method of venesection which reduces the circulating volume should be used. The third method of positive pressure with 100 per cent oxygen should be applied in all cases. Atropine is of questionable value since the fluid is a transudate.

The following is a case of pulmonary edema occurring during anesthesia and surgery and ending fatally.

REPORT OF CASE

The patient was a female 58 years old who had had a radical mastectomy for grade two carcinoma in March, 1939, under nitrous-oxide and ether anesthesia with an uneventful course. In June, 1943, a right simple mastectomy was performed for chronic cystic mastitis. In the history at that time it was stated that there were systolic and diastolic murmurs with some dyspnea on exertion. In July, 1943, the patient was again admitted with a diagnosis of acute pancreatitis but was dismissed two weeks later as improved. Three days later she was again admitted with a diagnosis of pancreatitis with cholecystitis and cholelithiasis. Cholecystectomy and exploration of the common duct was performed during two hours and five minutes of cyclopropane and ether anesthesia. The patient had a stormy convalescence and was discharged on August 27, 1943. On October 17, 1944, she was admitted for repair of a post-operative ventral hernia. At this time she weighed 155 pounds and was five feet three inches tall. The blood pressure was 150 over 90 and other findings were recorded as essentially normal. There was no chest x-ray. Nembutal, grains one and one-half was given two hours, preoperative. Morphine sulphate, grain one-quarter and atropine sulphate grain one one hundred and fiftieth were given three-quarters hour preoperative. The blood pressure immediately preoperative was 120 over 70, pulse was 98 and respirations 26. Anesthesia was induced with cyclopropane and maintained with cyclopropane and ether. The hernia was very large and an area of skin 25 by 9.5 centimeters was excised. Great difficulty was encountered in pulling the fascial edges together. After one hour of anesthesia 300 cc. of plasma was started and 35 minutes later 1,000 cc. of 10 per cent glucose in saline was started. Blood pressure remained at about 100 over 70 and the pulse at 80 and respirations at 20. Two hours after anesthesia was induced respirations rose to 24, and five minutes later they were 30. Blood pressure and pulse rate remained the same. The closure of the upper end of the incision was being finished at this time. Two hours and fifteen minutes after anesthesia was induced slight cyanosis was noted and respiratory exchange was definitely reduced. There had been no obstruction. Rales were heard over the chest. Seven hundred cc. of the glucose had been given and this was discontinued. The patient was intubated and much yellow frothy material was obtained. One hundred per cent oxygen under positive pressure was administered but very little oxygen could be forced into the lungs. The blood pressure rapidly fell to zero and two hours and thirty minutes after induction of anesthesia, no heart tones could be heard. An autopsy was not obtained.

COMMENT

There are several factors responsible for this case of pulmonary edema. There may be other unknown factors. The previous mastectomies probably reduced chest expansion and the increase of abdominal pressure on the diaphragm from the herniorrhaphy probably produced some anoxemia. This anoxemia could have weakened a heart which possibly did not have good function. This plus the increase of circulating volume from the plasma and glucose must have produced an acute cardiac failure with pulmonary edema following. This rapid and overwhelming edema prevented satisfactory treatment.

SUMMARY

A short discussion of acute pulmonary edema is given and a case occurring during anesthesia is presented.

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NEUROSES

THEIR EXPRESSION IN MILITARY AND CIVILIAN LIFE

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The power and destructiveness of man's emotions has never been more clearly demonstrated than in the recent war. The question of whether or not man can learn to control his own emotions, as well as a growing awareness of the cost to civilization of the increasing trend toward neuroses, has stimulated general interest in the subject of psychiatry. The following article is intended to discuss some fundamentals of dynamic concepts of the neuroses.

In the process of growing up, we have all made some sort of compromise peace with the world and with our emotions. We have learned to reach maturity because we were forced to give up infantile traits in order to be accepted by our families and by our cultural group—by society. But each person clings unconsciously to a number of infantile characteristics or ways of expressing emotion which are based on methods of solving life's problems utilized during earliest years.

The body, mind, and emotions, compose one unit, one personality, which functions in ways that are more primitive than we ordinarily realize. Every "normal" person has certain conflicting traits which struggle for the upper hand and which may in their struggle cause various nervous symptoms. Maturity and infantilisms clash in the depths of human nature. Neurotic persons are those whose nervous symptoms are present to a sufficient degree to be markedly noticeable, and a handicap. Yet the neurotic person may be perfectly well adjusted to certain phases of his life and just like everybody else in many respects. He may be unduly tense, anxious and irritable; he may make a career of hypochondria and nervous ills; or he may be afraid to leave the confines of his own street or neighborhood, although he may act quite normally in other respects. Such persons are then termed

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"neurotic" or "psychoneurotic," and their symptoms may be quite severe, or mild enough to interfere very little in ordinary civilian life.

Civilians have numerous opportunities to manipulate their environment and therefore can handle their emotional life more easily than those in service. They are able to alter their situations rather than change their personalities. They have some degree of free choice regarding work, locale, companionship, etc., and they may express temporary dissatisfactions by outbreaks of ill humor, or withdrawal from participation in events, and seek relief in hobbies and recreations. Soldiers are not free to do these things to any great extent. The civilian is allowed to indulge himself much more; if he is slightly "whacky" his friends do not mind; a phobia regarding guns or water will not bother him too much; all his peculiarities are accepted if he is a good fellow. For many civilians, of course, poverty, illness and domestic tragedies present problems as severe as the problems of the soldier, but these same misfortunes also add to the soldier's burdens, very often. In the army many outlets are inaccessible. For some, ambition may find a vent, and abilities and talents may be utilized to a high degree, but the majority of soldiers must remain anonymous, and must grimly dig in and fight. Among civilians a certain amount of defiance of authority may even be an aid in forging ahead and furthering a career—in the army rebelliousness against authority is likely to cause severe trouble. Therefore it is no surprise that civilians who "handle" their neurotic trends—and everyone has a few—find it much harder to adjust the more neurotic sides of their personalities to army life. Latent difficulties come to the fore, in the course of time—when a man is in service.

SERVICE REJECTIONS IN RELATION TO NEUROPSYCHIATRIC BACKGROUNDS

From January 1, 1942, through June 30, 1945, almost 1,750,000 men were rejected for military service because of neuropsychiatric reasons, the majority because of the presence of a neurosis. During the same period there were 1,000,000 hospital admissions for neuropsychiatric disorders, while 327,000 were discharged from the army during this time because of such disorders. What is a neurosis? How and why does it occur? Can it be cured? How serious an illness is it?

* * *

A person with a neurosis, if it is not too severe, can perform most of the essential tasks of daily living satisfactorily; he may be, and often is, a very intelligent and gifted person; but somewhere in his emotional makeup there is a persistent conflict which decreases his capacity for functioning adequately in life and produces symptoms. He may have certain fears that do not quite make sense, for instance he may be desperately afraid of high places and never be able to go up beyond the third or fourth floor of a city building; he may have a fear of crowds, or such an undue terror of certain diseases that no medical reassurance will put him at ease. He may become enraged over trifles, and alternate between periods of good resolutions and marked irritability, or suffer from marked overactivity of the sympathetic system. Some people are unable to eat in the presence of others, and are greatly limited in their social and even business activities because of this. Others feel impelled to think in odd ways—having to count, to go into the derivations of all words, or to reverse all decisions—and some feel compelled to go through elaborate rituals and ceremonials, for instance they cannot go to sleep at night unless everything is in a special place—shoes in a precise position under the bed, everything arranged just so, so that hours are spent preparing to sleep. To some degree, mild neurotic traits are almost universal. Irrational fears bother most people at some time or other, particularly in childhood—for instance fear of dark rooms, and ghosts. Compulsions of a mild sort are also fairly universal—many housewives are apt to become fanatical about scratches or dust on furniture, and men are perhaps equally fussy about certain routines connected with their businesses. There is a common group of milder character neuroses: inexplicable moods, feelings of failure, marital difficulties and feelings of insecurity make up what might be called a typical "modern" neurosis.

* * *

One interesting category of neurotics encompasses those people who complain of very few conscious fears and seem to have a free, zestful attitude toward life—but who have a tendency to "act out" their neurotic drives, and live according to a certain fateful need to repeat the curious pattern that always gets them into difficulties. These are the people who seem to live in a series of emotional peaks and depths, they have tragic love affairs, or their business successes and failures occur on a spectacular scale—or they may live for intense friendships which, time after time, end in disillusionment. "Great lovers," some criminals, rebels, eccentrics, and many gifted "originals" fall into this category. Women who fall in love only with men who are indifferent to them, or already married, business men who always place their trust in someone who is bound to defraud them, persons who crave excessive excitement and danger for its own sake, and those whose path always seems to turn instinctively in the direction of eventual personal disaster, are of this sort—as are those with insurmountable wanderlust, the hermits and recluses, and individuals constantly impelled to seek notoriety. A character neurosis is the name given to this type of neurosis. It may not interfere with artistic ability, inventive genius, talents or personal charm—but the character neurosis, or "fate neurosis" as it is called, is a warning signal to those who come in contact with the individual whose strange life pattern will tend to repeat itself, despite any vows to the contrary. In the army, most persons suffering from a definite character neurosis get into difficulties rapidly and are called "psychopathic personalities."

As has been stated, all types of neurosis, except a certain few, are dealt with more easily in civilian life, especially when the neurotic person can afford to direct his life as he wishes. In the army, where there is more frustration and regimentation, and where life's purpose is the grim one of warfare, a great many milder character neuroses which would be no great handicap and certainly no disgrace in civilian life, become almost crippling to the soldier; especially after years of service, his neurosis may tend to increase, necessitating his discharge. This is no sign of a permanently hopeless condition. Every normal individual has some degree of neurotic traits—and neurosis is entirely different from psychosis or insanity.

CONCERNING THE EXACT NATURE OF A NEUROSIS

What is the exact nature of a neurosis? Certain characteristics of all neuroses should be known by everyone:

(1) *A neurosis is based upon a conflict.* This conflict is not of the conscious sort which one can easily discuss and solve, by pure reason. It is an emotional conflict, and its extent and exact nature are sensed dimly, but not clearly understood by the individual concerned. For example, an aviation cadet who unconsciously is somewhat afraid to fly and has a hidden impulse to give up his flying training, but who is very ambitious and wants to prove to his friends and family that he can win his wings—has a conflict about flying and does not admit he has this conflict—*it is an unconscious conflict.* He does not admit he fears to fly at all. Instead he has headaches,

perhaps, and some nausea whenever he goes up in the air —or at night he has insomnia.

(2) *The neurosis affords both gratification and punishment.* The nervous invalid, retreating from life and renouncing most of its joys but at the same time being supported by the family and making them miserable, is a familiar example to every physician. Analysis of the neuroses usually reveals strongly repressed tendencies unacceptable to the individual's conscience. Renunciation of some of the gratifications of normal life, giving in to the conscience, and being punished, represent an unsuccessful handling of the conflicts, but at the same time the individual may get some satisfaction out of dominating his family through his neurosis.

(3) *The neurosis is characterized by an attempt to solve a present emotional problem by an earlier, more immature method.* It fails to solve problems in an adult fashion. In the case of the cadet with nervous headaches, he is grounded and is taken care of medically, absolving him from the responsibilities of further flying training. In the case of the neurotic alcoholic, there is a search for escape from adult responsibilities into the childishly blissful state of being "tight," and the dependence on others, even to the extent of inability to walk or talk sensibly, that comes with inebriation. Even in neurotic criminality the childish element is present in the complete avoidance of adult responsibility, and "taking by force," as a child tries to help itself to things. Neurotic attacks of rage, too, are a "giving way" of adult control; and sexual perversions are a return to the primitive impulses of the immature.

(4) *The repetitive nature of the neurotic act* stands out clearly during psychiatric consultations, although in the stress of daily living the tendency to repeat is rarely observed by individuals concerned. It is commonly stated that married couples who cannot get along together often choose the same sort of mate the next time, too. Neurotic difficulties or illnesses tend to come back over and over, and neurotic fears that disappear are apt to return in a new form. Most of the core of the neurosis is formed in life's earliest years; to a great extent scenes and people throughout later life are accepted, in one's emotional life, as analogous to those of the past. Competition with brothers, or sisters, and ambivalence toward parents in early life, are a pattern that is unconsciously repeated, for instance, in most of our lives. Often a dominant emotion of envy or competition in earliest childhood becomes a lodestar that guides and dominates all of life's later directions; competition with one person—ostensibly forgotten—later takes the form of a "divine discontent" and a lifelong drive toward achievement; the individual who is so driven cannot rest, but strives for success, never feeling satisfied; and he never realizes that it is an early competition (with a brother, or father, perhaps) that still leads him on. If difficulties befall the object against whom all this competition is unconsciously directed, then there may be a strong sense of guilt, instead of the competitive drive; instead of being smitten with unquenchable ambition, we now have a person who must suffer defeat, who cannot bear to win, because he carried with him a secret sense of guilt. Since all neurotic drives are repetitive in nature, the neurosis of an adult reflects the neurotic trends of an individual's earlier childhood, and the neurosis of the soldier likewise mirrors, to some degree, the difficulties of the same person in civilian life.

(5) *One further characteristic of neuroses:* since sexuality is one of the basic human drives, and since a severe neurosis cuts clear across the personality, affecting all basic urges, there are apt to be sexual difficulties such as impotence or frigidity present wherever there is severe neurosis, even though the person concerned does mended that he be given an opportunity to fly a different type of plane, after that—he did so successfully not readily admit this to be the case. The neurosis prevents the individual from making a mature sexual adjustment. In mild neuroses, the disturbances in the sexual life may take the form of guilty feelings or immature attitudes toward having children—or may be connected with alcoholism or promiscuity.

* * *

The growth of a neurosis is usually gradual. Life in our day has its hardships and many neuroses become much worse when the time comes to accept the responsibilities of earning a living, marrying, and raising a family. To some, army life for a time offers an escape from civilian responsibilities, although it soon brings frustrations and restrictions of its own. In treating men in service psychiatrically, several things have to be borne in mind; their early background, their civilian experience, their army experience, and the situation in which the complaints came to the surface. Sometimes a temporary change in the external situation is all that is required to give adequate relief to an acute flare-up of neurotic difficulty.

The best "cure" for a neurosis is insight into the emotional conflict which is at the root of the disturbance, and understanding of how the specific emotional conflict evolved, in a given individual's personal history—and then an intelligent approach to the conflict with a practical attempt to solve it.

TYPES AND SYMPTOMS OF NEUROSIS

Under the general heading of Neuroses, the types and symptoms most frequently seen are these:

Hysteria. For example, the pilot of a fast new type of fighter plane was sent for a consultation because he was unable to swallow and had a perpetual muscular constriction of the throat. Nothing was found physically wrong. Just before this difficulty arose, he had witnessed the death of his best friend in the same special fast type of plane he flew himself, and then he had the difficult task of conveying the body of his friend to the boy's parents. After this, his throat felt constricted, he could not swallow. This type of symptom is known as a hysterical symptom, in this case *globus hystericus.* All of his emotion was tied up in the one symptom. He talked about his visit to the parents of his lost buddy, and said that the parents of the dead boy had wanted to adopt him as their son since he had no family of his own. Now, talking to the psychiatrist, he began to realize for the first time that he really had a severe conflict between his desire to stay with this elderly couple as their son and the necessity to go back to his dangerous career. He had unconsciously begun to identify himself with the dead son, and felt that a similar fate was awaiting him. He felt especially guilty because the night before the accident both boys had been drinking together, in defiance of rules. Instead of being able to accept food from the dead boy's parents, he found his throat bothered him and he could not eat. The constriction in his throat worried him and he forgot all these other emotions connected with his friend's accident, the grieved parents, etc., so great was his anxiety about his own inability to swallow. This illness prevented his continuing to fly. In this case, the emotional conflict was really between his repressed wish to cease to fly, the urge to live with his friend's parents and be taken care of by them—and his conscience and self-respect, which required him to continue as a fighter pilot.

Competitive feelings toward the dead comrade, and anxiety about meeting a similar fate, and many other conflictful feelings were all shunted off into a muscular tension which resulted in the constriction of the patient's throat. Relief from this symptom was obtained with insight into its entire emotional setting. It was recom-

In this case the function of innervation of the throat muscles was distorted by the conflicts—the energy connected with the conflicts became converted into the symptom. There is nothing wrong physically, in many such hysterical cases, and yet the limb, voice, eye, or some other part of the body which could hitherto be moved voluntarily, ceases to function.

All sorts of strong and unpleasant emotions, such as anxiety, hostility, and guilt, may be forgotten and bound up in muscular tension, rather than remembered consciously. Thus a hysterical symptom is created.

In the services such cases are seen fairly frequently. Following an injury to a foot, hand or arm, when healing has taken place slowly, the limb may continue to be painful and circulation poor—and one more soldier is apparently incapacitated, although there is actually no physical finding any longer. Such cases have often been found to be of hysterical nature, although originally the injury was actual.

* * *

Another manifestation of neurosis commonly seen in civilian and military life is the *phobia*. This is a reaction of disproportionately great fear to situations which need not be inherently very dangerous. For example, a returned veteran who had been a gunner, began to break out into sweats and to tremble when riding in elevators or other enclosed places. Even in a moving picture theater he grew panicky. He could recall no past fears of this sort. Not until he was interviewed by the psychiatrist did he see any connection between his fear of enclosed spaces and the fact that his worst moment in combat had been when his own plane was shot up and he was trapped in the ball-turret, unable to get out. He managed to wrench himself free and to parachute down to earth. That entire incident was too painful to remember, except under treatment—and yet it was necessary for him to recall the emotions bound up with it, and to learn to discriminate between the previous fearful situation and his present safe one, in order to free himself of the phobia.

In many cases of phobia, the sufferer develops certain rituals or he feels that special circumstances are necessary to relieve him from his fears. He may have a water phobia, and yet be able to swim if a friend accompanies him. A person suffering from claustrophobia may be able to enter elevators if his wife is with him; a talisman which is carried along protects many people from their particular fears. If nothing is done about a phobia, it has a tendency to spread. The person who fears elevators, begins to fear more and more places that seem closed-in. His personal life grows increasingly restricted, once he allows himself to look around for things to fear. Yet if the emotional conflict hidden behind a phobia is understood, the actual fear may often be relieved. In young children phobias are particularly common; their inception occurs just when the youngster has reached some emotional impasse, perhaps unknown even to himself. Among adults, fear of being run over, being infected, fear of water, of high places, fire, enclosed spaces, wide places, and of various sorts of animals or snakes, etc., are common phobias and may be of such slight proportion that the person is scarcely bothered by such fears at all. It is only when they become so strong as to cripple normal living that the sufferer usually seeks aid.

* * *

Inhibitions occur more in civilian life than in the army, as those with extremely inhibited characters usually are not taken into the armed services. Some inhibitions are directly related to phobias—such as inability to tolerate high places, cross bodies of water, etc. Certain very mild inhibitions occur in practically everyone: Inability to sing, to do mathematical problems, to cook, sew or engage in competitive sports, or to speak in public, characterize many of the people one meets. Some inhibitions, seemingly unimportant, may hinder the course of one's life. Many college students who are apparently brilliant and have retentive memories simply cannot study for examinations; so serious may this inability to study be, that professional careers have to be given up. Or a young man may be a keen disappointment to his family because he cannot stand helping his father and learning his father's business. This is a "work inhibition" and is founded on a deep conflict in regard to the emotional aspects of the entire situation. A conflict of this sort is not clearcut and obvious. On the surface he may be ambitious and may be fond of his father, and feel "There is nothing I want more than to please my father by becoming his assistant. But I cannot stand this type of business." If the matter were explored in detail, all sorts of conflicts would be brought to light, in relation to the father, the business, and the total situation.

Socially inhibited people never enjoy social gatherings and may have headaches or be bathed in sweat at some of the simplest social functions. They may present a shy, wallflower aspect, or may attempt to hide discomfort by garrulous talking and exaggerated liveliness. Most people at various times feel a certain amount of reluctance to joining social groups—but only neurotic individuals feel perpetually averse to companionship.

Inhibitions of any of the normal and necessary activities of life may occur, and they usually mask an extreme conflict about all that particular function represents to a given individual. This conflict is usually one that the individual never has faced; it is unconscious, and originated in childhood. For example, some attractive young girls never have dates because they somehow antagonize men. They try to make themselves attractive, and yet they are inhibited in their femininity. They may be exceedingly sarcastic, with men—or very, very critical of their male companions, finding no one who lives up to their ideals. Behind these externalities, it is their emotional coldness toward men that controls their inability to attract suitors.

* * *

Compulsion neuroses, when fully developed, may require prolonged treatment for relief. Occasionally they may consist of compulsive ceremonials, washing rituals for instance, or a compulsion to doubt everything and inability to come to any decisions, compulsion to commit repetitive acts of atonement—or a constant feeling that "unless I do so-and-so, great harm will come to someone I love." There comes to mind a patient, a chemist, who had to go back to his laboratory to recheck every experiment. Sometimes he would awaken in the middle of the night and go back to perform simple tests over again, convinced that otherwise some terrible mistakes he had made would result in the deaths of many persons.

* * *

Depression is a category of neurosis frequently seen. In severe cases of depression there is retardation of movement, sleeplessness, refusal of food, strong self-destructive or suicidal tendencies, and, in the psychotic depressions, even hallucinations and delusions. But mild forms of depressions are the most common, and do not differ from a "fit of the blues." An unrecognized component of every depression, even a mild one, is usually a guilty feeling which in turn is due to some latent hostility which is not freely expressed because it would be directed against someone toward whom respect, love or obedience is due. During mourning, very often, depression is prolonged and unusually severe where there has been conflict about the beloved person. The prolonged depressive reactions of soldiers to the death of comrades are usually associated with profound conflicts. There may have been intense competition with comrades, for success in various ways, for promotions—for military achievements—for mere survival. After the death or injury to a comrade, feelings of guilt and heavy depressions are almost a universal reaction, even though the soldier may try to stifle his emotion by heavy drinking, silence and brooding, or an outer air of imperviousness. When feelings of guilt are brought to the surface and recognized as universal—and their basis is seen to lie in the mixture of aggression, competitive urges, and positive feelings, which it is the way of human nature to react—"talking it out" does a great deal of good. But usually the depressed person is averse to talking or thinking very much about the "load" he bears, and avoids the prospect of going into the details of his complicated feelings. The family should not urge or prod him. Depressions tend to wear away, if they are not too severe. However, depressed people are likely to harm themselves at least in a negative way by not looking out for their own welfare —not taking sufficient care against accidents, for instance. Alcoholism may grow out of a depression; that, too, is self-destructive in essence, although it provides temporary release.

* * *

Anxiety States.—Some degree of anxiety is present in almost all neuroses. Particularly in wartime, anxiety was reactivated not only in the soldier but also in the civilian, who lived in a world where nightmarish human fantasies were daily being realized. Neurotic anxiety is different from normal fear in that it persists chronically, after the immediate source of normal fear is no longer present. The human organism cannot tolerate anxiety for long without developing various symptoms, as defenses against it.

Anxiety reactions shown by a great many veterans upon their return from overseas were characterized by: restlessness, tenseness, tremulousness of the hands and face, irritability, depression and feelings of guilt, various degrees of insomnia, physical fatigue, continued preoccupation with battle experiences, startle reactions, and battle dreams. Excessive drinking as an attempt to relieve anxiety was common; and the need for finding sexual outlets was intensified by the anxiety of some of these individuals. In the majority, these symptoms tended to die down spontaneously if stabilizing factors were present in the home environment.

The anxiety reactions of veterans, known as operational fatigue, are based on three causative factors: (1) Hardships, excessive combat experiences, and unusually harrowing events which no normal personality could tolerate. (2) Predisposition—usually in the form of a previously well-hidden psychoneurosis which emerged in combat because the young man's former methods of dealing with anxiety in civilian life or training proved inadequate under fighting conditions. (3) Reaction to traumatic events in combat to which the soldier was specifically vulnerable, emotionally.

In addition to these cases of operational fatigue, there are many cases among veterans in which the frustrations and discipline of army life created anxiety states, entirely apart from combat experience.

* * *

Psychosomatic Symptoms.—The incidence of physical illness of emotional, or nervous, origin, has been on the increase since the beginning of World War II. Functional gastro-intestinal symptoms, functional headache, and cardiovascular syndromes were frequently seen during military service. Research has been conducted in the psychological factors in asthma, hypertension, peptic ulcer, skin diseases, endocrine functions, etc., and has produced a stimulating and challenging body of literature, in the past fifteen years.

Chronic unrelieved emotional tensions produce psychosomatic illness. Such a disease is not a short-circuit visceral expression of an emotion, but is often a normal physiological concomitant of an emotional state that is chronically prolonged. Hysterical symptoms are conversion symptoms. An unbearable acute emotional conflict is rendered innocuous in hysterical states as in the case of globus hytericus described earlier in this paper. The chronic psychosomatic illness differs from the hysterical symptom, in that it deals with chronic unresolved emotional states which, in time, affect the body's functioning, through the sympathetic nervous system.

For example, one patient was interviewed psychiatrically, in the army, because he suffered from severe urticaria, as well as fatigue and restlessness which incapacitated him for duty, much of the time. Adrenalin produced mild and temporary relief, and was the only drug that helped his urticaria. It was found that his urticaria attacks occurred for the first time when he heard that his wife was neglecting their children and going out with other men, while he was away in the army. He obtained an emergency furlough and went home to investigate, but on the way he "swelled up like a balloon," and all he could do when he reached home was to go to bed and stay there for the entire furlough. His wife and children came to live with him, near his army post, but he continued to worry, because although he got on well with his wife when they were together, he felt he could not trust her any more, should they be separated. At the time he was sent for psychiatric consultation, his wife was pregnant again. It was pointed out to him that ever since the episode with his wife, his greatest fear had been that she would leave him. He was surprised when he was told he was still very angry at his wife and at the same time afraid of losing her. He thought all this over, and a few days later, he came back very much relaxed, with no more urticaria. His fundamental need to be dependent had been threatened. He had not cared to express his rage, for fear of antagonizing the person he was dependent upon, his wife. He had never dared to express rage, and for as long as he could remember, he had never cried. Now his temporary dependence upon the therapist helped him over the difficulties of readjustment to his wife. This patient was typical of a good many whose main problem centered at home, even though he was in the army; his symptoms tended to prevent or postpone his being sent overseas, although he was too conscientious to "goldbrick" consciously.

The physiological side of such cases as these present fascinating research problems. As psychiatric exploration continues, parallel with medical research, the entire field of psychosomatic medicine promises to be one of the most interesting branches of modern medicine.

SUMMARY

Varieties of neurotic difficulties have been described. So far as symptomatalogy goes, there is fundamentally no difference between the neuroses of civilians and soldiers. The conflict situation, whether of recent origin as in the war neuroses, or of chronic history, cannot be thoroughly dealt with until it is first made conscious. The adaptation of the neurotic to reality is handicapped by his emotional status. He is forced by his neurosis to adapt himself to the world as the victims were adapted to the bed of Procrustes in the Greek myth.

2039 Midvale Street.

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CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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American Medical Association will hold its annual session this year in San Francisco. Dates: Monday, July 1 - Friday, July 5, 1946.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

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In Memoriam

Crosby, Isaac Fory. Died at Pasadena, December 19, 1945, age 81. Graduate of the University of Illinois College of Medicine, Chicago, 1889. Licensed in California in 1921. Doctor Crosby was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Donaldson, Arthur Norton. Died at Santa Ana, December 16, 1945, age 57. Graduate of the College of Medical Evangelists, Loma Linda-Los Angeles, 1915. Licensed in California in 1915. Doctor Donaldson was a member of the Orange County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Mulholland, Stanley Clifford. Died at Santa Barbara, March 4, 1946, age 52. Graduate of the University of Minnesota Medical School, Minneapolis, 1923. Licensed in California in 1929. Doctor Mulholland was a member of the Santa Barbara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Ring, Oluf Andreasen. Died at San Francisco, March 29, 1946, age 47. Graduate of the University of California Medical School, Berkeley-San Francisco, 1929. Licensed in California in 1929. Doctor Ring was a member of the San Mateo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Templeton, Wayne King. Died at Riverside, March 18, 1946, age 49. Graduate of the University of Cincinnati College of Medicine, Ohio, 1922. Licensed in California in 1931. Doctor Templeton was a member of the Riverside County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Terry, Lawrence. Died at Alameda, March 5, 1946, age 50. Graduate of Northwestern University Medical School, Chicago, Illinois, 1932. Licensed in California in 1942. Doctor Terry was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Whiffen, Robert Albert. (Lieutenant, Army of the United States). Died near Gilroy, March 7, 1946, age 31. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1941. Licensed in California in 1941. Doctor Whiffen was a member of the Monterey County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

California Procurement and Assignment Service for Physicians Completes Its Work

(COPY)

FEDERAL SECURITY AGENCY
Procurement and Assignment Service
For Physicians

April 10, 1946.

To: Chairmen and members of County Committees Procurement and Assignment Service of Northern California.

Gentlemen:

Please don't burst out crying but this is the swan song of the Procurement and Assignment Service for Physicians in California. This office will officially close on May 15, 1946, and the pertinent records accumulated during the busy years of the emergency will be filed under the jurisdiction of the California Medical Association so that at least an historical record of much of the important work that was done can be made accessible if, as and when it is necessary.

Regarding your own files, I feel you should go over accumulated material and throw out any unimportant records or if you see fit to destroy all records. I think that the committee members should discuss this with the chairmen. If there is material which would be of importance to keep, it would probably be advisable to file this with the County Medical Society. However, there is in some files certain material which might be harmful to certain individual doctors if improperly used at some future date and, therefore, I would urge care and wisdom in being sure that such harmful material is destroyed so that it cannot come into the hands of anyone who might use it unfairly or for personal reasons.

I know you will all feel relieved, as I do, that this strenuous program is coming to a close. It has been a tremendous job and I cannot begin to thank you for your fine coöperation and loyalty in helping me carry on this program. It is good to know that from many sources, including Washington to the state, county and community levels, I have received a great deal of praise for our work. This is because of your fine work and coöperation.

With my kindest personal regards to each and all of you and again many thanks, I remain,

Sincerely yours,
s/Harold A. Fletcher, M.D.,
California State Chairman
for Physicians.

Room 1422, 450 Sutter Street,
San Francisco 8, California.

Medical Veterans Attend U. C. Medical Center

One hundred and fifty veterans are now attending classes at the University of California's Medical Center, in the Medical School, the College of Dentistry, and the College of Pharmacy.

Graduate students include 14 doctors holding appointments as assistant resident physicians; one assistant resident in dentistry; two clinical assistants; two x-ray technicians; three students in dermatology and syphilology; and two in pharmaceutical chemistry.

The remainder of the 150 veterans are undergraduates, most of whom went into the services before they could complete their medical education.

In addition to providing training for such a large group of ex-servicemen, the University of California Medical School, through University Extension, is giving refresher courses of instruction in various phases of medicine for doctors who have returned to civilian practice from the armed forces.

New Army Regulation Authorizes Professional Graduate Training for Medical Corps Officers

An important forward step in the establishment of professional graduate training for Army doctors has been taken with the enactment of the new Army Regulation 350-1010, which authorizes the establishment of an organized program of graduate education for "the elevation of the general level of professional qualifications of all Medical Corps officers."

Medical Corps officers selected for training in medical surgical specialties by the Surgeon General's Professional Training Committee will be assigned to a Medical Department installation approved by the Council on Medical Education and Hospitals and by the appropriate American specialty board for training in the particular specialty, according to the regulation. The minimum duration and scope covered by the training will be such as to meet the certification requirements of the specialty board concerned.

Upon approval of the Surgeon General, specialty training may be supplemented by service school instruction or a civilian teaching institution, but the time employed in such training may not exceed one-third of the total training period. Officers desiring supplemental training must submit an application to the Surgeon General endorsed by their commanding officer, and must include reasons for the recommendation of such training in that application.

Postgraduate training in medical and surgical subspecialties and preventive medicine will be offered at Medical Department service schools, installations, or at civilian teaching institutions. Application for these courses must also be indorsed by the commanding officer and submitted to the Surgeon General with a statement of the applicant's qualifications.

An education committee will be organized at each medical installation caring for sick and injured, which will be responsible for the organization, supervision and coördination of the medical educational program. The commander of the installation will serve as chairman of the committee, which is to be composed of qualified members of the professional staff and authorized civilian consultants. This committee is also responsible for the over-all organization and supervision of the program, and is to maintain such records as are necessary to indicate the progress of each medical officer entering the training. Assurance of a well-rounded training program and the establishment of a basis for the evaluation of each individual's professional development is also a part of the committee's duties.

Installations conducting approved graduate training in medical and surgical specialties will maintain a staff of qualified specialists. Teaching ability will be the major factor in selecting chiefs of services and sections at these installations, and the officers selected will be professionally acceptable to the American specialty boards concerned. Medical officers undergoing residency-type training are to keep diaries on medical cases worked up, investigative work, collateral reading, case presentations at clinical pathologic conferences, and studies in basic sciences. In addition to a periodic review of these diaries by the education committee, each applicant for an American specialty board will present his diary with his application. Continuous effort will be made to improve the teaching program. In selected large station hospitals, the development of the program will be toward approved internships, and residencies in medicine and general surgery. Affiliation with adjacent civilian medical facilities will be utilized wherever possible.

As a guide in the conduction of the program, the requirements necessary for certification by American specialty boards and the principles set forth in "Essentials of Approved Residencies and Fellowships" and "Essentials of an Approved Internship" will be followed. These pamphlets were prepared and published by the Council on Medical Education and Hospitals of the American Medical Association.

Each quarterly period, a report on each medical officer will be submitted by chiefs of services through channels to the Surgeon General. These reports, in addition to indicating the proficiency of the officer, will include any pertinent remarks concerning his progress and special training problems.

U. C. Medical School Veterans to Be Honored

A welcoming banquet in honor of members of the staff of the University of California Medical School will be held on the evening of April 25 at the Palace Hotel, San Francisco.

Approximately 125 members of the medical faculty, who have been on military leave of absence, will be present for the banquet. All members of the faculty but ten have returned from service.

The guest speaker for the evening will be Major General Paul R. Hawley, medical director of the Veterans' Administration, who will come from Washington, D. C., for the dinner.

ASTP Program to Be Terminated by First of June

The Medical Army Specialized Training program for medical students will be terminated by the first of June this year, according to ASF Circular 56, which is dated March 6, 1946.

Enlisted men assigned to ASTP for medical training will be disposed of as follows:

"Enlisted men assigned to ASTP for medical training who are scheduled to graduate from medical school before July 1, 1946, will not be separated from the Army regardless of age, length of service, critical score, or by virtue of having three or more children under eighteen years of age. They will not be permitted to enlist in the Regular Army. They may be separated under existing regulations pertaining to discharge of enlisted men because of undue hardship or because of importance to National health, safety, or interest. They will not be separated for any other reason except as individually authorized by the War Department."

The Circular makes the following provisions for enlisted men assigned to ASTP for medical training who are not scheduled to graduate from medical school prior to July 1, 1946:

"Those enlisted men who meet current War Department criteria for separation may be discharged. Those enlisted men who are eligible for discharge under April 30 or June 30 criteria and who do not plan to continue their medical studies may be reassigned within the service command until the date of their discharge if their services are needed. If their services are not needed, they will be discharged.

"Those enlisted men who do not meet War Department criteria for separation, who do not plan to continue their medical studies, or are not acceptable at an accredited medical school will be transferred to Brooke Army Medical Center, Fort Sam Houston, Texas.

"Those enlisted men who are not eligible for separation, who signify their intention to continue their medical studies, and are acceptable at an accredited medical school will be released from active Federal Service and transferred to the Enlisted Reserve Corps. Authority for such release will be Section I, AR 615-363, and this circular. These men will furnish a certificate from the dean or other similar official of a medical school approved by the Council of Medical Education and Hospitals of the American Medical Association."

Provision is made by the circular that these men must sign a statement requesting transfer to the Enlisted Reserve Corps and agreeing to certain conditions pertaining to termination of enrollment or requests for transfers between medical institutions.

Army Program Prevents Importing of Disease

There is little or no risk of introducing foreign disease into the United States through returning military personnel from abroad, according to an annoucement by the Office of the Surgeon General, which pointed out that the most careful estimates anticipate only moderate danger in a few cases.

This conclusion was reached after a world-wide survey by the Interdepartmental Quarantine Commission, which was jointly established by the Secretaries of War and Navy and the Administrator of the Federal Security Administration to study this problem.

With the end of the war and return of the bulk of combat forces, it is now possible to review actual results on a preliminary basis. Though tentative, highly optimistic conclusions appear warranted, the announcement stated.

To date no acute outbreak or secondary spread of an imported disease has been reported. While more slowly evident diseases may be identified later, it should be remembered that the traffic of war has gone on for four years, giving ample time for discovery of such diseases.

The 440,000 hospitalizations for malaria reported among Army personnel during the war fall short of pessimistic predictions for what has proved to be the commonest infectious disease of troops abroad.

Even with the consideration that a portion of infected persons are liable to recurrence after their return to the states, conditions in this country are generally unfavorable for the spread of malaria and the chances of community risk are very small.

The special danger of cholera, smallpox, plague, epidemic typhus, and yellow fever is a matter of historical record. Immunizations were employed against all these diseases by the Armed Forces along with water purification, environmental sanitation, and disinfestation and insect control. This preventive medicine program was exercised even under combat conditions and its effectiveness was shown by Army records. The high general level of sanitation, insect control, and alert medical care available here forms the final link in the protection of this country from imported diseases.

The risk of importing disease from abroad has been less in some respects than in normal prewar traffic and the credit for these results has been attributed to the modern preventive medicine program of the Army and Navy.

Cases of exotic disease did occur, the announcement stated, but extensive investigation of likely hazards and critical application of preventive and corrective measures were effective in reducing risks to small proportions.

Surgeon General Kirk Outlines the Remaining Task

The care of the war's wounded is only a part of the medical responsibility of the Army Medical Department, with five thousand neuropsychiatric patients, one thousand tropical disease patients, and three hundred blinded soldiers still in Army hospitals, Major General Norman T. Kirk, Surgeon General of the Army, said in a recent talk at the annual dinner of the Society of Surgeons of New Jersey.

"In the nine centers specializing in hand and plastic surgery, there are 11,500 patients needing an estimated 31,000 operations," General Kirk pointed out. "The plastic surgeons who had been working twelve to fourteen hours daily, six days a week, to carry this load were most of them eligible for separation on points. It was necessary to freeze them in the service. I explained to them why we had to do it. They understood, and they are still doing their job.

"Wherever American soldiers are on duty anywhere in the world, there must be medical officers with them. The flow of battle casualties has mercifully ended. But young men are still subject to all the usual diseases, from colds in the head to acute appendicitis. They are still subject to accidents . . . they still must be protected against tropical disease. They still must be protected from the diseases born of wartime devastation and malnutrition. They still must be looked after at staging areas and on their way home. They still must be examined most thoroughly at separation centers, both for their own sakes and for the sakes of the taxpayers who will later foot the bill for errors, as well as for genuine disabilities. Those who will replace them at home and overseas must still be examined at induction centers. Prisoners of war must still be cared for. Displaced persons are frequently medical problems before they are anything else."

In 1940, just after the fall of France, the General said, the United States Army consisted of approximately 250,000 men and the Medical Corps of about 1,600 officers, of whom nearly 75 per cent were in the Regular Army. By December 7, 1941, there were 1,613,000 men in the Army and 11,390 officers in the Medical Corps. Although the increment in the Army was chiefly through the Selective Service, that of the Medical Corps consisted entirely of volunteers.

"In short, the Medical Corps can no more be permitted to fall apart, to 'demobilize by demoralization,' than can the rest of the Army," General Kirk concluded. "The hardship to be borne by men who must remain in uniform longer than they like is simply an essential part of what has gone before. It cannot be evaded without placing in jeopardy the victory won in combat. It is indispensable to the completion of the job."

Physicians in the Department of Medicine and Surgery of the Veterans' Administration Medical Staff Organization

Public Law No. 293, 79th Congress, created a Department of Medicine and Surgery in the Veterans' Administration under the direction of a Chief Medical Director, January 3, 1946.

Under this law, the Administrator of Veterans' Affairs will establish regulations to replace the Civil Service rules which formerly governed V.A. professional personnel. Until such regulations are established, the following will prevail:

Status.—Through appointment, promotion and disciplinary boards to be set-up by the Administrator, the Veterans' Administration will have complete supervision of its own physicians, dentists and nurses, based upon their professional competence. Physicians appointed to the Department of Medicine and Surgery will not be Civil Service employees.

Salaries.—A new salary scale commensurate with training and experience has been established, as follows:

Grade	*Pay per Annum*	*Positions*
Chief	$8,750-$9,800	Clinical Director or Chief of Service in large hospital; a teacher.
Senior	$7,175-$8,225	Chief of Service in medium-sized hospital; Chief of Section in large hospital; a teacher.
Intermediate	$6,230-$7,070	Chief of Service in small hospital; Chief of Section in medium-sized hospital; a teacher.
Full	$5,180-$6,020	Assistant to Chief of Service or Section.
Associate	$4,300-$5,180	Senior Ward Officer.
Junior	$3,640-$4,300	Junior Ward Officer.

Specialists.—The value of specialized training is recognized. Specialists certified by the American Specialty Boards and the Veterans' Administration will be paid an additional 25 per cent of base pay up to a limit of $11,000 a year.

Salary Deductions—Retirement.—Although not Civil Service employees, physicians, dentists and nurses in the Department of Medicine and Surgery will be subject to the regulations of, and will receive the benefits under, the Civil Service Retirement Act of May 22, 1920, as amended. Five per cent deductions are made from all base salaries for retirement which is based on age or disability and an aggregate service of at least five years. Honorable military service not forming basis for pension is counted for retirement in the same manner as Civil Service.

Quarters.—On-Station accommodations for physicians and their families are limited. When occupied, rentals proportionate to the size and type of quarters, are deducted from basic salary. Most V.A. physicians live off-station in adjacent communities.

Qualifications.—Basic requirements for physicians are:

1. Citizenship in the United States.
2. Graduation from a school of medicine approved by the Administrator of Veterans' Affairs.
3. License to practice as a physician in a state or territory of the United States, or in the District of Columbia.
4. Adherence to the physical requirements of the Department.
5. Professional experience as required.

Veterans' Preference.—Preference will be given to qualified veterans.

Applications.—For the present, submit one copy of Civil Service Form No. 57. Applications should *not* be submitted to the U. S. Civil Service Commission. Follow instructions below:

Physicians seeking appointment to Junior or Associate grades should apply to the manager of the nearest V.A. Regional Office, Hospital or Center. Managers are authorized to make appointments in these grades subject to post-audit of qualifications at Washington. When surplus at station to which initially assigned, physicians are subject to transfer to another station. Preference of location may be stated and will be given consideration consistent with the needs of the service. . . .

Transportation.—V.A. physicians pay their own travel expenses to the location of their first assignment. Subsequent transfers, when in the interest of the service, are made at Government expense and include movement of household goods and dependents.

Clinical Experience.—Close association with civilian medical associations and teaching centers will assure modern scientific medicine in V.A. establishments. The large number of cases handled and the opportunity for continuity of contact with individual cases over a period of years provides outstanding opportunity for extensive professional experience.

Residencies.—Residencies are being established at V.A. Hospitals that are near medical schools or teaching centers, for men who will remain with the Veterans' Administration until they are qualified for specialty board certification.

Recommendation for residency must be made through the "Deans Committee," a committee consisting of the Dean of Medical Schools and any members of his faculty of professional rank whom he may desire to appoint. At present there are 45 Grade A colleges out of 75 Grade A colleges coöperating in the residency program which, today, affects 76 out of 97 V.A. hospitals. These are the schools near enough, geographically, to work with V.A. hospitals in such a plan.

For detailed information about residencies, consult the Dean of your Medical School or write to the Director of Research and Education, Veterans' Administration, Washington 25, D. C.

Consultants.—Appointment of Consultants or Attending Physicians must be upon recommendation of the Deans Committee of the particular V.A. hospital to which assignment is requested. For full information, consult the Dean of your Medical School or write to the Director of Research and Education, as indicated under "Residencies," above.

Summary.—Physicians, dentists and nurses now on duty with the Veterans' Administration, will be continued in their present Civil Service positions pending establishment of procedures and standards for appointment to the department. Appointment of physicians, dentists and nurses subsequent to January 3, 1946, will be made directly to the Department of Medicine and Surgery by the Administrator of Veterans Affairs upon recommendation of the Chief Medical Director.

With the enactment of Public Law No. 293 and the demobilization of millions of World War II veterans the medical task of the Veterans' Administration becomes a challenge and an opportunity.

It is a challenge to the country to provide the best medical care and treatment for war-torn veterans.

Summary.—It is an opportunity for qualified physicians, dentists and nurses to reap the finest in professional progress and experience while giving the highest calibre of service of which they are capable to a deserving segment of humanity.

Information.—For further information consult the manager of the nearest V.A. Hospital, Regional Office, or write to: Chief, Operations Division, Office Director of Personnel, Veterans' Administration, 7th Floor, 49 Fourth St., San Francisco 3, California.

Military Clippings.—Some news items of a military nature from the daily press follow:

New Streptomycin Allocation Program to Make Provision For Civilian Use

The Army Medical Department, which has received many requests for supplies of streptomycin to be used in treating civilian cases, has announced today that all civilian inquiries and requests for this drug are to be sent to Dr. Chester S. Keefer, Evans Memorial Hospital, 65 East Newton, Boston, Massachusetts. Telephone Kenmore 9200.

Dr. Keefer is Chairman of the Committee on Chemotherapeutic and Other Agents of the Division of Medical Sciences, National Research Council, and has been authorized to handle civilian requests, providing they are submitted by a physician giving sufficient technical information to enable him to decide whether streptomycin is indicated in the treatment of the case.

Distribution of limited supplies of streptomycin to civilians through the Committee on Chemotherapeutic and Other Agents of the Division of Medical Sciences, National Research Council, has been provided for in the allocation program recently established by the Civilian Production Administration. Other agencies receiving allotments of the scarce drug include the Army, Navy, Veterans' Administration, and the United States Public Health Service.

Although there has been a general misconception that the Army controls the total streptomycin supply, actually an approximate 30 per cent will be allotted to the Army from the production for the month of March. The bulk of the limited supply received by the Army has been employed in treating urinary tract infections associated with spinal cord injuries, and a few serious infections which have proved resistant to penicillin. At no time has the allotment been adequate to permit any extensive research, such as experimental work on the treating of tuberculosis. In order that Dr. Keefer may obtain an adequate supply for civilian appeals, the Army has voluntarily agreed to a delay in its March delivery of streptomycin from producers.

Grants-in-aid of approximately $500,000 for the clinical study of streptomycin, contributed in equal shares to the National Research Council by 11 pharmaceutical manufacturers, has already been announced by the Chemical Division of the Civilian Production Administration. The participating firms constitute the Streptomycin Producers Advisory Committee of the C.P.A.

Dr. Keefer, who headed the clinical investigation of penicillin, will be in charge of the similar program on streptomycin and will submit recommendations, together with a report on the results. The C.P.A. has announced that there will be no commercial distribution of streptomycin at this time, nor will the producers supply the drug directly for civilian requests. Physicians have been asked not to submit requests for streptomycin if the cases are susceptible to the action of the sulfonamides, penicillin and other therapeutic agents.

The production of streptomycin, which was approximately 3,000 grams last September, is expected to increase to nearly 27,000 grams by March. A companion drug to penicillin, streptomycin is produced in a similar manner, by fermentation and chemical extraction, and, like penicillin, requires carefully controlled conditions of temperature, air and sterility. It is expected to prove a valuable supplement in cases where infections do not respond to penicillin treatment, but studies have not yet advanced to the point where the methods of administration or the amenable diseases are definitely known.—Bulletin No. 40, U. S. Army Technical Information Division.

Out-Patient Treatment For All Veterans Who Have Filed Service Claims Now Possible

Immediate out-patient treatment for all veterans who have filed claims for service connected disabilities, regardless of whether they have been adjudicated, is now available through the 6,200 members of the California Physicians' Service, The Veterans' Administration announced today.

A joint statement issued by Col. Thomas J. Cross, V.A. chief here, and Dr. Chester L. Cooley, C.P.S. secretary, said care by C.P.S. physicians in their offices will be authorized provided the veteran does not live within a reasonable distance or have easy access to a V.A. out-patient office or hospital.

Emergency hospitalization in a private hospital may be authorized for service connected disabilities when the condition of the veteran precludes travel or when no bed is available at a V.A. hospital.

Speeds Up Treatment

Colonel Cross termed the agreement one of the "biggest" steps in speeding up medical treatment for veterans with service-connected disabilities.

The following categories of veterans are entitled to treatment by C.P.S. physicians of their own choosing:

1. Those who have filed a claim for service incurred disabilities and are receiving compensation or pension.

2. Veterans who have filed a claim which is pending adjudication. If the claim is eventually disallowed the veteran will not be thereafter entitled to out-patient treatment from C.P.S.

3. Veterans having acute inter-current illnesses which are judged to retard recovery from or aggravate a service-connected disability.

4. Disabled veterans receiving vocational rehabilitation training will receive treatment for all conditions regardless of service connection, a lack of which may be judged to interrupt their training.

Available to Women

5. Female veterans are entitled to out-patient treatment in the same categories as male veterans.

6. Veterans whose claim requires a physical examination will be notified by the V.A. of the proper procedure in contacting a C.P.S. doctor to perform the examination should a V.A. hospital, regional or sub-regional office not be reasonably available for such an examination.

C.P.S. is a voluntary insurance system founded eight years ago by the California Medical Assocation and its membership includes a great majority of the State's general practitioners and specialists.

Colonel Cross, who directs V.A. activities in California, Arizona, Nevada and Hawaii, said similar plans are expected to be put in operation in other states under his jurisdiction.—Oceanside *Blade-Tribune*, March 25.

American G.I. Got Best Medical Care Given Any Army, Anywhere

Surgeon General Says More Men Saved From Death, Spared Suffering and Mutilation Than Was Ever Thought Possible

"The American armed forces had better medical care in World War II than the soldiers of any army ever before received," according to Major General Norman T. Kirk, Surgeon General. "More men were saved from death, more men were returned to military usefulness and more men were spared suffering and mutilation and disfigurement than was dreamed possible at the end of World War I or, for that matter, at the beginning of World War II."

Writing in the April 6 issue of *The Journal of the American Medical Association*, Major General Kirk praised the Medical Corps officers for their humanity in the care of paraplegic patients, those suffering from paralysis of the legs and lower part of the body, and then he enumerated the "remaining task."

"At the end of August, 1945, there were 312,000 patients still in hospitals. At the end of Demember there were 180,000, 1,400 of whom were paraplegics. By next June it is estimated that there will still be approximately 70,000, of whom at least 600 will still be paraplegics.

"Add to these paraplegics other categories of patients who also present special needs. At the end of November there were 11,350 patients in the nine centers set aside for plastic and hand surgery, who, it was estimated, still needed almost 31,000 operations. The plastic surgeons who had been working 12 to 14 hours daily six days a week to carry this load were most of them eligible for separation on points. We froze them in the Army. I explained to them why we had to do it. They understood, and they are still doing their job. So are the physicians who are taking care of the 5,000 neuropsychiatric patients now in the hospital, 2,000 of them in closed wards, and the 1,000 patients with tropical diseases, the 1,800 with tuberculosis, the 300 blind men who are being rehabilitated and the thousands of other casualties of the war who, by the orders of the Chief of Staff, the Secretary of War, and the President of the United States, must not be discharged to civilian life or transferred to the Veterans' Administration till Army doctors have done for them all that modern medical science and skill can do."

In conclusion the author says:

"Wherever American soldiers are on duty anywhere in the world, there must medical officers be with them. The flow of battle casualties has mercifully ended. But young men are still subject to all the usual diseases, from colds in the head to acute appendicitis. They are still subject to accidents, some of them inherent in their dangerous tasks, some of them, as an English physician caustically put it, arising from 'the stupidities of fools.' They still must be protected against tropical diseases. They still must be protected from the diseases born of wartime devastation and malnutrition. They still must be looked after at staging areas and on their way home. They still must be examined most thoroughly at separation centers, both for their own sakes and for the sakes of the taxpayers who will later foot the bill for errors as well as for genuine disabilities. Those who will replace them at home and overseas must still be examined at induction centers. Prisoners of war must still be cared for. Displaced persons are frequently medical problems before they are anything else.

"In short, the Medical Corps can no more be permitted to fall apart, to 'demobilize by demoralization,' than can the rest of the Army. The physicians in civilian life would no more wish that to happen than do the physicians still in uniform. All military service, as has been well said, entails some hardship. The hardship to be borne by men who must remain in uniform longer than they like is simply an essential part of what has gone before. It cannot be evaded without placing in jeopardy the victory so arduously won in combat. It is indispensable to the completion of the job."—*J.A.M.A.*, April 6.

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

A.M.A. Sessions in San Francisco—July 1-5, 1946

American Medical Association Convention committees of the San Francisco County Medical Society are moving forward on all fronts in preparation for the July 1-5 meeting.

The San Francisco Convention and Tourist Bureau is handling all details pertaining to exhibits, housing and halls.

The following information is set forth for the benefit of members who may have received requests from out of town confreres for hotel accommodations: *Such requests should be referred in writing to the A.M.A. Housing Bureau, Room 200, Civic Auditorium, San Francisco 2, California.* All applications for hotel reservations should contain the expected arrival and departure date of the guest. The Tourist Bureau has "frozen" about 4,000 hotel rooms in San Francisco for the period of the Convention. Thousands of applications have been received, but the Bureau is delaying confirmation until a more accurate estimate can be made of the load.

Tentatively scheduled are meetings of collateral societies and groups prior to the general convention. Among such meetings are:

American College of Allergists.
American College of Chest Physicians.
American Society of Clinical Pathologists.
American Heart Association.
Association for the Study of Internal Secretions.
American Neurological Association.
American Academy of Applied Nutrition.
American Ophthalmological Society.
American Proctologic Society.
American College of Radiology.
American Radium Society.
American Academy of Tuberculosis Physicians.
Woman's Auxiliary of the American Medical Association.
American Medical Women's Association, Inc.
American Society for the Study of Sterility.

The entertainment program for the Woman's Auxiliary is being planned by special committees. Some of the features include sight-seeing tours, points of interest in San Francisco, teas, luncheons and receptions. Highlight of the program will be a formal dinner for wives and husbands.

⁂

A list of chairmen of local committees follows:

General Committee

John W. Cline, Chairman; Stanley H. Mentzer, Vice-Chairman; Chester L. Cooley, Robertson Ward; Frank J. Kihm, Secretary.

Finance

G. Dan Delprat, Chairman; William Reilly, Vice-Chairman.

Registration

Allen T. Hinman, Chairman.

Hotels

M. Laurence Montgomery, Chairman.

Entertainment

T. Henshaw Kelly, Chairman; Philip K. Gilman, Vice-Chairman.

Subcommittee for House of Delegates Dinner

Salvatore P. Lucia, Chairman; Warren D. Horner, Vice-Chairman.

Subcommittee for President's Reception

Alson R. Kilgore, Chairman.

Subcommittee for Opening Session

Hans Barkan, Chairman; Thomas F. Mullen, Vice-Chairman.

Subcommittee for Golf

James W. Morgan, Chairman; Bradford F. Dearing, Vice-Chairman.

Information (Including Ushers and Pages)

Kenneth D. Gardner, Chairman.

Publicity and Printing

Lambert B. Coblentz, Chairman.

Scientific Exhibits

Dwight L. Wilbur, Chairman.

Transportation and Automobiles

Glenn F. Cushman, Chairman; Paul D. Michelson, Jr., Vice-Chairman.

Subcommittee for Clubs

Frederick W. Kroll, Chairman; Robert C. Martin, Vice-Chairman.

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Committees on Sections and Section Work

1. *Internal Medicine*
   Walter Beckh, Chairman; Roberto F. Escamilla, R. Emmet Allen.
2. *Surgery, General and Abdominal*
   H. Glenn Bell, Chairman; Carleton Mathewson, Jr., Franklin I. Harris.

3. *Obstetrics and Gynecology*
   Herbert F. Traut, Chairman; C. Frederic Fluhmann, Albert M. Vollmer.
4. *Ophthalmology*
   George N. Hosford, Chairman; C. Allen Dickey.
5. *Laryngology, Otology and Rhinology*
   Clain F. Gelston, Chairman; Crawford Bost, Charles W. Leach.
7. *Experimental Medicine and Therapeutics*
   Mayo Soley, Chairman; Donald A. Carson, Francis L. Chamberlain.
8. *Pathology and Physiology*
   David A. Wood, Chairman; Karl B. Eichorn, James F. Rinehart.
9. *Nervous and Mental Diseases*
   George S. Johnson, Chairman; Karl M. Bowman, Edmund J. Morrissey.
10. *Dermatology and Syphilology*
    John M. Graves, Chairman; Norman N. Epstein, Arne E. Ingels.
11. *Preventive and Industrial Medicine and Public Health*
    J. C. Geiger, Chairman; Rodney R. Beard, Nelson J. Howard.
12. *Urology*
    Clark M. Johnson, Chairman; William A. Sumner, Morrell E. Vecki.
13. *Orthopedic Surgery*
    Frederic C. Bost, Chairman; Donald E. King.
14. *Gastroenterology and Proctology*
    Hugh Rose, Jr., Chairman; Charles A. Noble, Jr., Robert A. Scarborough.
15. *Radiology*
    Leon Henry Garland, Chairman; Alexander Petrilli, A. Justin Williams.
16. *Anaesthesiology*
    William Neff, Chairman; Hubert R. Hathaway, Walter Lawrence.
17. *General Practice*
    Clyde D. Horner, Chairman; Ivan C. Heron, Wesley E. Scott.

A.M.A. Auxiliary Convention Chairmen and Committees

Mrs. Clifford Lang, General Chairman of Arrangements; Mrs. Norman Morgan, Co-Chairman.

Credentials and Registration

Mrs. Harry Hund, Chairman; Mrs. Frank Lowe, Co-Chairman.

Advisory Committee

Mrs. Ralph Eusden, Mrs. Harry Hund, Mrs. Frank Lowe, Mrs. Roger McKenzie, Mrs. Anthony Monty, Mrs. Hobart Rogers, Mrs. Edward Schulze.

Finance

Mrs. Howard Dixon, Chairman; Mrs. Raleigh Burlingame, Co-Chairman; Mrs. Walter Lawrence.

Headquarters

Mrs. Robertson Ward, Chairman; Mrs. Louis Roncovieri, Co-Chairman.

Hospitality

Mrs. Daniel Morton, Chairman; Mrs. A. Justin Williams, Co-Chairman.

Transportation and Sightseeing

Mrs. Edmund Morrisseey, Chairman; Mrs. Frank Hand, Co-Chairman.

Printing and Tickets

Mrs. Keene Haldeman, Chairman; Mrs. William Newman, Co-Chairman; Mrs. James Warren.

Publicity

Mrs. Maurice Korshet, Chairman; Mrs. Elsworth Quinlan, Co-Chairman.

Junior Aides and Pages

Mrs. Lee Hand, Chairman; Mrs. Henry Gardner, Co-Chairman; Mrs John Sampson, Co-Chairman.

Flowers and Decorations

Mrs. Norman Epstein, Chairman; Mrs. Robert Newell, Co-Chairman.

Supplies

Mrs. Lloyd Shone, Chairman; Mrs. William O'Grady, Co-Chairman.

Favors

Mrs. Vance Strange, Chairman; Mrs. Russell Merrett, Co-Chairman; Mrs. William A. Reilly, Mrs. Lee Schahinian, Mrs. Frederick H. Lawrence.

Music

Mrs. Francis H. Redewill, Chairman.

Golf, Tennis and Swimming

Mrs. Loren Chandler, Chairman, Golf; Mrs. L. Henry Garland, Co-Chairman, Tennis; Mrs. Edmund Morrissey, Swimming.

Tea

Mrs. Elsworth Quinlan, Chairman; Mrs. L. Henry Garland, Co-Chairman; Mrs. George Kulchar, Co-Chairman.

Past Presidents' Luncheon

Mrs. Roger McKenzie, Chairman.

Auxiliary Luncheon

Mrs. Guy Schoonmaker, Chairman; Mrs. Dohrmann Pischel, Co-Chairman.

Auxiliary Dinner

Mrs. Jesse Carr, Chairman; Mrs. Matthew Hosmer, Co-Chairman.

Indoctrination Course Receiving National Attention

A number of State and County Medical Associations are requesting details of operation of the indoctrination program instituted at the beginning of this year by the Los Angeles County Medical Association. So that this information may be presented to those making inquiries, and to review for our own members the purposes of the indoctrination program, the following is presented.

* * *

The rapid growth in membership of the Los Angeles County Medical Association during the past several years created a considerable problem for the Committee on Admissions and the Council, which acts upon all applications. It became apparent that doctors of medicine, beginning practice for the first time in Los Angeles County, would profit greatly by the experience of those who had practiced here for many years. Certain situations are met in Southern California that are not common in other parts of the country.

It was known that many physicians seeking membership had little, if any knowledge of the functions of the County Medical Association, or the State or American Medical Associations. It was considered important that they be informed of the importance of these organizations in which they sought membership, so that they could take their proper place in organizational activity, and obtain to the full the benefits offered.

During 1945 the Council of the Los Angeles County Medical Association appointed a committee to study the proposed indoctrination program. The report of this committee was approved by the Council. Dr. Louis J. Regan, President, reported the appointment of the General Committee on Indoctrination and six sub-committees

Indoctrination Course of Los Angeles County Medical Association

Five times since the beginning of the indoctrination program the Lounge of the Association has been filled with applicants for membership. Above is shown a picture of the group that attended one of the lectures.

—each sub-committee charged with the responsibility of presenting a lecture to applicants. The program as developed by the committee consists of a series of six lectures—two to be given each month, which must be attended by the applicant before his application will be considered by the Council.

The subjects of the lectures are as follows: Medical Organization, Health Insurance, Medical Public Relations, Medical Ethics, Medical Education and Medical Economics, and Medical Malpractice.

The first lecture in this series was presented on January 25. More than 200 applicants attended this lecture. Five lectures have been presented to date to audiences of 200 or more applicants.

Because of previous commitments, illness, or for other reasons considered adequate, applicants who have been unable to attend any one or all of the lectures given on the third and fourth Fridays of each month will be given the opportunity of making up lectures especially presented for them on Sunday afternoons. The dates for the Sunday lectures have not been set, but are determined when the need for them arises. All applicants who have failed to attend any of the regular series are requested to notify the Secretary's office, and will in turn be informed as to the time of the make-up lecture.

For each one of the six subjects presented, a special sub-committee of four members was appointed. Two members of a sub-committee handle a lecture. This avoids too great a hardship for the men presenting the lectures—only two lectures a year to be given by each sub-committee member.

When a group of applicants has attended the six lectures, they will be interviewed in smaller groups by members of the sub-committees—following which the Committee on Admissions will report to the Council on these applicants for membership.

This indoctrination program, instituted by the Los Angeles County Medical Association, was presented to the Council of the California Medical Association and approved. The Council of the State Association recommended that similar programs be instituted by other County Medical Associations in California.

Word of this program has spread throughout the country. The office of the Secretary has received many requests for details as to its operation. In the beginning, when applicants learned that it was mandatory to attend the six lectures, some of them considered it an unnecessary procedure. However, after their attendance at the first meeting the attitudes of many of them who had been critical changed. Those who are conducting the program honestly believe that these lectures are not only being well received, but are being considered exceedingly valuable. The objective of the indoctrination program is a better-informed membership.

Public Relations and Alameda County Medical Association

The Bulletin of the Alameda County Medical Association for April printed the following item:

⁂

MEDICINE ASSISTS C.I.O.

"Medical Care for All the People" is the advertised guarantee of the Alameda County Medical Association. A reproduction of one of our paid advertisements *(Tribune Year Book)* is reproduced below.

This pledge of the ACMA was recently translated into action:

A representative of the Strike Welfare Committee of the C.I.O. called the ACMA office requesting aid for members of their machinists' union and others who were on strike. It was stated that some of these men and their families needed medical care for which they were unable to pay.

The C.I.O. was informed that the ACMA guarantees medical care to all of the people, regardless of ability or inability to pay, and that, C.I.O. strikers being people, they are naturally included in the guarantee. Therefore, strikers were told to go to their family physicians, to request needed medical services, and to make arrangements to pay when they returned to work.

Because of the interest of newspapers in the problem, a press release was issued. (The same written article was given to both The *Post-Enquirer* and The *Tribune*. In its rewrite, The *Tribune* failed to mention the fact that payment for medical services would be expected after the striker returns to work. However, The *Post-Enquirer* rewrite contained this important point.)

The public reaction to these newspaper stories is obvious: The medical profession in Alameda County, as elsewhere, is interested primarily in the service it can render to humanity. Even the C.I.O., an organization that has officially and aggressively promoted legislative schemes to regiment the doctor, can call for and receive his professional services—"on the cuff," which often means gratuitously—in time of need.

These newspaper stories, advertisements, and others to follow, will convince any thinking legislator who is about to vote on a compulsory health insurance bill of the *fact* that there is already medical care for all—even for C.I.O. strikers, who might be said to be *voluntarily* out of work and out of funds. Why, then, with this guarantee of universal medical care, and with *voluntary* insurance also available, should the C.I.O., or anyone want compulsory health insurance? What argument remains for state medicine?

This, we believe, is the beginning of a good public relations program.

* * *

Medical Attention Open to Strikers

Men on strike and their families were notified today by the Alameda County Medical Association that needed medical attention is available and is being provided by private physicians, regardless of ability or inability to pay.

In a statement to the C.I.O. Strike Welfare Committee, Dr. Warren Allen, president of the association, reminded workers that a patient need only go to his family doctor and ask for medical attention in order to receive it.

Any exceptions should be reported to the association, according to Doctor Allen. A Bureau of Medical Economics has been established by the association at 364 14th Street to guarantee universial medical care.—Oakland *Tribune*, March 6.

* * *

Medical Aid Set For Strike Families

Striking Oakland area workers may obtain medical care today despite the possibility that many may not be able to pay for services immediately, the Alameda County Medical Association announced.

"In every case where medical service is needed, the sick person's family doctor will deliver the needed services and will await payment until the head of the family gets back to work," Dr. Warren Allen, president of the association, declared.—Oakland *Post-Enquirer*, March 6.

* * *

Medicine Assists C.I.O.

This editorial, and the following advertisement must convince every Alameda County physician that there is only one way to assure ourselves that our guarantee of universal medical care, regardless of ability or inability to pay, will be carried out in every instance: The Bureau of Medical Economics, which is directed by physicians, must handle the collection of delinquent medical accounts. Otherwise, how can the doctor *know* that payments on his accounts are not forced in cases where payment results in depriving the patient or his family of the other necessities of life?

Your participation in the collection department of the Bureau of Medical Economics is essential to the development of the public relations program of the A.C.M.A. Commercial methods in the collection of medical accounts, perhaps more than anything else, are responsible for public dissatisfaction with the economics of medicine.

The Bureau collects more; but it protects your ethical obligations to your patients.

* * *

Face Tomorrow Without Fear

Most folks, especially those with families, worry a lot about the ever-present possibility of the combined personal catastrophes of losing their jobs or other source of income, and then having a major illness in the family, too.

But if they knew about doctors, about medical ethics and the physician's traditional ideal of service to humanity, folks would know that all this worry isn't necessary, because for more than 2,000 years no ethical physician has ever turned his back upon human suffering because he might not be paid.

And then some people are just negligent, and don't pay the doctor, even when they could well afford to do so.

To balance these things fairly and humanly, physicians of Alameda County have established the Bureau of Medical Economics. Among the many purposes of this Bureau is prevention of abuse of the physician's freely-given charity, and regardless of ability or inability of the patient to pay, to *guarantee medical care for all the people.*

So face tomorrow without fear. Whatever happens, needed medical care is available to you. Just visit your family physician, who is a member of the

ALAMEDA COUNTY MEDICAL ASSOCIATION
364 14th Street, Oakland 12, TWinoaks 3367

* * *

(This paid advertisement appeared in the *Post-Enquirer* and will be published in the *Tribune* Year Book.)

Sections on "General Practice" Being Organized in Larger Component County Units of C.M.A.

The trend in recognition of "general medical and surgical practice" is growing apace, as witness the following from *The Bulletin* of the Alameda County Medical Association, for March:

SECTION ON GENERAL PRACTICE ORGANIZED IN LOS ANGELES

General practitioners of Los Angeles have organized themselves as the "General Practice Section of the Los Angeles County Medical Association."

Dr. Eric A. Royston, chairman, stated in the *Los Angeles Bulletin:* "Having organized our Section in Los Angeles County, we are now in a position to help some of the other county associations with their organization. It will not be long before this new General Practice Section idea spreads throughout California, and we hope it will be only a few short months before we have a Section on General Practice in the State Association."

* * *

The incorporation of a "General Practitioners Association" for Eastbay-Oakland has been announced by Dr. Stanley Truman, acting chairman of the first board of directors of the new organization.

The purposes of the association outlined in its articles of incorporation are: "to protect the right of the general practitioner to engage in medical and surgical procedures for which he is qualified by training and experience;" "to promote and maintain high standards of general practice of medicine and surgery; to encourage and assist in providing post-graduate study for general practitioners; . . . to perpetuate the relationship between family doctor and patient . . ."

The "Hospital Committee" of the new organization is directed by the By-Laws "to maintain close contact with the staff activities of the hospitals in order that representation of this organization be maintained on each hospital staff," "to recommend to the board of directors such changes in the facilities, conduct, or functions of the various hospitals as may seem indicated for the general welfare of the public or profession," and "to assist any of the hospitals in furthering their programs."

The "Public and Professional Relations Committee" of the GPA will recommend "such action . . . as may be necessary to assure adequate representation of the general practitioner groups" and "to provide liaison with the public and other medical organizations."

The GPA By-Laws require that members take a minimum of one month's post-graduate work each three years. Specialists are to be invited to sit on an advisory committee.

To be eligible for membership in the General Practitioners Association, the applicant must be engaged in the general practice of medicine and surgery, must be a graduate of an AMA-approved medical school, a member of this county medical association, and he must have had a rotating internship in an accredited hospital, following which he must have been in the private practice of medicine for at least two years.

"Our primary purpose is to maintain a high level of general practice in the communities we serve," Dr. Truman told *The Bulletin*. "But in order to maintain this standard, it is necessary that the all-important position of the general practitioner be recognized and protected. We believe this organization will make a significant contribution to the unity and effectiveness of the organized profession."

How Texas Is Proceeding in Re: State and County Medical Society Committees on Hospital and Medical Service

(COPY)

STATE MEDICAL ASSOCIATION OF TEXAS

Fort Worth 3, Texas, March 7, 1946.

To: Presidents and Secretaries of County Medical Societies of State Medical Association of Texas:

Re: Appointment of County Medical Society Committees on Hospital and Medical Service.

Gentlemen:

I am addressing you jointly so that in the event either of you is away from your office for any reason, the other will receive a copy of this communication and see to it that as prompt action as possible is taken on the subject of this letter.

President Dr. H. F. Connally requests that each county medical society immediately set up a committee on hospital and medical service composed of at least three members or as many more as thought desirable, by whatever procedure the Society chooses—appointment by the president or election by the Society. It will probably be best to appoint or elect the committee on an overlapping term of office basis so that there will not be a complete turn-over in membership of the committee with each new administration, and there can be continuity of work, records and policies, but that may be decided by your Society.

The important point is that the committee be set up promptly and that it begin to function promptly. There is enclosed, herewith, a form calling for a report from the committee at its earliest convenience regarding the *present* medical and hospital situation in your county medical society area; and for the opinion of the committee, which can be considered as representing the opinion of your Society, regarding the need of any additional physicians and *what kind*, if needed, and any additional hospital or hospitals and *what kind*, if needed. It is impossible to discuss this subject completely in a letter but it is believed the enclosed form indicates what is desired. It has been made as simple as possible.

It is imperative that this matter be given immediate and diligent attention. No other subject is more important to the preservation of the independent practice of medicine in Texas. We must know on a state-wide basis what is needed to be certain that all of the people of Texas have adequate medical and hospital facilities and *be able to support our contentions* in that regard with *accurate facts and figures, carefully and thoughtfully assembled by those qualified to advise in local areas throughout Texas.*

The Hill-Burton bill providing Federal funds for construction of hospitals and public health facilities in all areas of the United States *where they are needed and where they can be supported by their communities:* is certain to pass Congress in the near future. Already a survey has been started by the State Board of Health, the official agency in Texas, to determine where such hospitals and public health facilities are needed in Texas, and, of greatest importance, *where* they will be economically supported by their communities after being established.

The State Medical Association is officially represented on the Advisory Council to the State Board of Health in this matter. This official representation, which is composed of the President and Secretary of your Association, Chairman of the Board of Trustees, Chairman of the Board of Councilors, Chairman of the Legislative Committee, Council on Medical Economics and Public Relations Committee, wants to have for their guidance *information gathered from the basic units of the Association*—the 126 county medical societies of Texas, when they are called upon to consider the recommendations of the administrator who will conduct the survey for the Board of Health.

Please advise as promptly as possible the names of your "Committe on Hospital and Medical Service", designating the chairman, and we shall appreciate being assured that the committee is on the job and will furnish the information desired on the enclosed form as expeditiously as possible.

Kindly hand to your Committee on Hospital and Medical Service one of the communications addressed to you and *both* forms, so that after execution of the latter one may be kept in the files of the Committe and one may be sent to this office. Quarterly reports will be asked of the Committee.

Please do not wait for a regular meeting of your Society to act in this matter. Please give it immediate attention, calling a special meeting of your Society, if necessary.

Fraternally yours,
s/HOLMAN TAYLOR, M.D.
Secretary.

1404 W. El Paso Street.

* * *

MEDICAL SERVICE

Population served by physicians of area (est.) ....
Total number of physicians in area ....
Retired or Inactive ....
Fully Active ....
    Below 65 years of age ....
    Above 65 years of age ....
    General Practitioners ....
    E.E.N.T. ....
    Pediatricians ....
    Obstetricians ....
    Urologists ....
    Orthopedists ....
    General Surgeons ....
    Other Specialists (List kinds and number) ....
    ....

* * *

On the back of this report, or an attached sheet, please state number of additional physicians, if any, needed to render adequate medical care to *people of area* and *people served by physicians living in area*, and kinds of physicians needed — surgeon, pediatrician, etc. Please specify clearly and in detail, *where* they are needed (name and population of town), whether hospital facilities will be open to such physicians and proximity to such hospital. Estimate possible number of people such physicians may be called on to serve and nearness of other physicians for medical help and consultation.

If no doctor is needed, it should be so stated.

* * *

HOSPITAL SERVICE

Population served by hospital of area (est.)..........
Total Number of Hospitals..................
Total Number General Hospitals.............
Number of beds....................
Number of T.B. Hospitals...............
Number of beds....................
Number Mental Hospitals...............
Number of beds....................
Name other kinds of hospitals and number of beds in each..........................
....

* * *

On the back of this report form, please state number and kind of hospitals, specifying number of beds in each needed in area to adequately serve the people of the area. Hospitals should be recommended only for communities which need them and which can support them financially after they are established. If none are needed, please say so. Your area may be adequately served by a hospital or hospitals in adjoining county areas.

Date....................
Signed ...., *Chairman.*
Address ....

COMMITTEE ON MEDICAL ECONOMICS

A Lay Editorial on S. 1606 (Wagner-Murray-Dingell Bill)—Some Implications

(COPY)

TOTALITARIAN LEGERDEMAIN

After some months of calculated hesitation, awkward attempts are now being made in Congress to pass the administration's so-called "National Health Bill."

This is *not* a bill that would *improve* the "national health" in any way.

As an unscientific therapeutic innovation, it would undoubtedly be more harmful, on the whole, than beneficial.

But it has three characteristics that appeal to the New Deal mentality.

It is demagogic.

It would divert additional large sums of money from the pay rolls and pay envelopes of American enterprise into the federal Treasury to be expended by federal officeholders.

And it would inflate an existing federal service into another enormous bureaucracy with dictatorial "authority" over the lives of the American people.

The scheme behind the "National Health Bill" did not originate in America.

Its outlines were prescribed for Socialist Britain by Sir William Beveridge: and before that its *formulae were in evidence in Communistic Russia and Nazi Germany.*

It was thus borrowed from the politically *backward* nations of Europe: and naturally among its most ardent supporters are the Communists and their fuzzy-minded fellow travelers.

Embodied formerly in an omnibus "General Welfare Bill" which was so flagrant that Congress would not even consider it, the pending features have been extracted and reintroduced under the new title by the same sponsors —Senators Wagner and Murray and Representative Dingell.

The bill would constitute the Surgeon General of the United States Public Health Service as a czar over medical, dental, surgical and hospital service, and over the drug and pharmaceutical industries as well.

That office is now occupied by Dr. Thomas Parran, an advocate of "socialized medicine."

On December 10, Doctor Parran sent a mimeographed letter to all officers of the Public Health Service in which he described the bill as being "designed to implement the proposals of the President" made to Congress on November 19, 1945.

"Every officer of the Public Health Service," said Doctor Parran, "will wish to familiarize himself with the President's message and *will be guided by its provisions* in making *any public statement* likely to be interpreted as representing the official views of the Public Health Service."

This was plainly *an order* to Public Health Service officers to ballyhoo for the "socialized medicine" bill.

Recognizing it as such, *New Yoork Medicine,* the official organ of the Medical Society of the County of New York, said editorially on April 5:

"Thus it would seem that the administrative and executive branches of the Government have received a mandate from the 'Commander in Chief' to support the Wagner-Murray-Dingell Bill. . . .

"Is not such a directive a violation of the constitutional right of free thought and free speech?

"Is it customary for the subordinates to conform to the administration's policy or political purposes, even in respect to controversial measures not yet passed upon by Congress?

"The United States Public Health Service includes many physicians in private practice, volunteers in emergency hospital units, reserve officers in the Medical Corps and members of the Public Health Service Reserve itself.

"Many of these physicians unquestionably have serious doubts as to the desirability of the President's health program, particularly that part which calls for compulsory health insurance.

"Is the medical profession, as a result of this action, now on advance notice as to the type of directive they may expect from governmental medicine?"

The medical journal entitled its comment *"Directed Thinking?"*

If that kind of regimented thinking would be bad for the medical profession, how much worse would the same kind of government-directed *medical service* be for the American people?—Editorial in San Francisco *Examiner,* April 15, 1946.

New York Health Plan Shelved

The Temporary State Commission appointed by the New York Legislature in 1944 to study the question of compulsory medical care has now reported to Governor Thomas E. Dewey. The majority report, signed by nine members, stated they were not prepared to recommend any plan for medical care and hospital insurance until there has been more experience in the field of medical and hospital experience.

* * *

The New York Tribune, February 16, 1946, in quoting the majority report said:

> "A comprehensive plan for medical care includes hospitalization; physician's care at home, in the office, and in the hospital; nursing care, diagnostic services, and limited dental care. The cost of this type of plan covering every resident of the State has been variously estimated but it would probably be at least $400,000,000 a year. This would mean a cost of at least $30 per capita. The commission is of the opinion that this sum represents too great an expenditure to be imposed on the people of the State, either directly or indirectly through governmental authority, until there has been more experience in the field of medical and hospital insurance.
>
> "There would be serious difficulties in administering medical care to 13,000,000 people and avoiding abuses and deterioration in the quality of service. Furthermore, the facilities in the State with respect to medical, dental, nursing and hospital care would need to be greatly expanded."

The report said the commission was unwilling to recommend "an experiment on such an enormous scale and at such cost and risk" and endeavored to find "some plan less than a comprehensive plan, which might be used to test out the practicability of a compulsory prepayment plan of medical care," but that there appeared to be no such plan on which the members could agree.

After fifteen months' study, the majority report went on, the commission "has come to the conclusion that to make an experiment in a field heretofore nongovernmental and an experiment at such great cost and affecting 13,000,000 people, is something which deserves further study before definite action is taken."

Voluntary Sickness Insurance—Campaign to Show Its Advantages

The California Medical Association, sponsors of the California Physicians' Service, will soon launch a $100,000 newspaper advertising campaign to increase enrollment in the doctors' prepaid medical care plan, Ed Clancy, executive secretary of the California Committee for Voluntary Health Insurance, told the State Convention of Accident and Health Managers Clubs in San Francisco on Tuesday (March 7). The medical profession, however, he added, is equally interested in the success of all health and accident insurance programs.

Clancy said his committee was formed to educate the people of California as to the value of health and accident insurance; its importance for the family's financial security in an emergency; its low cost features in comparison with any bureaucratically controlled State or Federal system, and the guarantee it generates automatically for ever-advancing health standards by keeping virile the fundamental incentives in the medical profession.

"We are to hammer home the fact that better care—the care provided by the family physician, means better health, and that health and accident insurance means life saving insurance," he said.

"Our objective," he added "is to make all Californians health insurance conscious and have them voluntarily obtain some form of this vital protection. With this accomplished, we will have eliminated all basis for the clamor of the bureaucrats for compulsory health insurance, and we will have eliminated their attempts to control our lives—at least insofar as insurance and medicine are concerned."

Clancy urged insurance companies to increase their advertising appropriations, or to gear their campaigns to run simultaneously with the California Physicians' Service advertising during "Voluntary Health Insurance Week"—one of the promotional efforts his committee will assist in staging in all sections of the State.

"We want the coöperation of the insurance business and the medical profession for the mutual preservation of both," he concluded. "We want it now and we want it at any time in the future when our American free enterprise system may be under attack from any source."—San Francisco *Underwriters Report*, March 14.

British Disclose Medical Care Program For All

London, March 21.—(AP.)—Britain's Labor government today published a broad national health program proposing government-financed medical and dental care for all the 40,000,000 people in England and Wales.

Details of the program, introduced in the House of Commons Tuesday, were disclosed in a government white paper which estimated the annual cost would be $68,000,000.

Opposition Expected

The plan, as drafted by Health Minister Aneurin Bevan, was expected to be strongly opposed by the Conservatives and by the British Medical Association.

The bill provides for:

Public ownership of all hospitals, except those giving instructions to doctor and free hospitalization for all patients who need it.

Establishment of new public health centers for hospital, clinical, dental and specialist services, with free treatment and medicine.

Eye examinations and the provision of glasses at no cost.

Aid for Poor Districts

Gradual distribution of doctors by paying higher rates of compensation in doctor-scarce industrial and rural districts and by declining permission to new doctors to establish themselves in wealthy doctor-saturated districts.

Doctors who work in public health centers would be paid a salary plus a small fee for each patient. Others could practice part time in the centers and carry on a private practice for people who elect to stay outside the public health plan.—Los Angeles *Times*, March 22.

Five Year Health Program Is Goal of Montana Solon

Washington, March 25.—(AP.)—Senator Murray, Democrat of Montana, called today for a five year program to make Americans healthier.

"The time has come," he said, "to stake out long distance health goals for America's future."

Murray announced in a statement he has asked the American Medical Association, the American Dental Association and some 180 other organized groups in the health field for their opinions as to what should be the "specific health goals" for the next five years.

The Montanan is chairman of the Senate Education and Labor Committee which will open hearings April 2nd on proposed legislation for national health insurance. The measure contemplates payroll deductions, similar to social security, for prepayment of medical and hospital costs.

This and other proposed health bills cannot be considered properly, Murray said, until "we know what our health objectives should be."

Saying he was informed "veritable miracles" can be achieved "if we fully mobilize our health resources," Murray added:

The purpose of this survey on health goals is to get definitive views from the entire medical and health profession on such questions as how far can we increase the average expectation of life

How far can we go in wiping out or controlling cancer, tuberculosis, pneumonia and other diseases?

How many doctors, dentists, hospital beds and health clinics do we need?

When all the estimates have been received, I shall prepare a comprehensive summary for use by the committee and the public.—Sacramento *Bee*, March 25.

Senators, Doctors Hold Vivid Debate on the Health Bill

Doctors and lawmakers today exchanged conflicting opinions about a "National Health Bill," including compulsory Government insurance for medical care.

The doctors, appearing for the 125,000 physicians in the American Medical Association, told the Senate Labor Committee the Administration's "Health Bill" would:

Bring "socialized medicine" and regimentation of both doctors and patients, and result in inferior medical care.

Cost some $4,000,000,000 for a year or more and add 1,500,000 persons to Government payrolls.

Fail to produce as good medical care as voluntary prepayment insurance programs which A.M.A. now is sponsoring through a non-profit corporation.

Senator Pepper declared doctors are "prejudiced witnesses" and the proposed legislation is "not a matter on which the people of the country have selected the doctors to act for them."

Dr. Roscoe L. Sensenich of South Bend, Ind., chairman of the A.M.A. board of trustees, agreed but added the lawmakers should consult the medical profession on possible results.

"We Senators won't make any more money if we pass a health bill but a lot of you doctors will make less, if we don't," Pepper told the witness.

The lawmakers, including Senators Murray (D., Mont.), Pepper (D. Fla.) and Tunnell (D., Okla.), defended the health plan and declared:

The American Medical Association and its controlling House of Delegates, are "far behind the times."

Some doctors refuse to "treat poor people unless they got cash on the barrelhead."

Opponents of the health program had "misrepresented the facts" by terming it "socialistic and dangerous" and were "spending thousands of dollars" on propaganda against it.—San Francisco *Chronicle*, April 18.

A.M.A.'s National 10 Point Health Program

In a full page, box display, the *Connecticut State Medical Journal* for April presents the A.M.A.'s program as follows:

Doctor—Inform Your Patients!

In the best interests of the people's health, the American Medical Association has come forward with A National Health Program, *A Common-Sense Ten Point Program,* in which the national organization urges . . .

(1) High Standard of Living, with a minimum standard of nutrition, housing, clothing, and recreation as fundamental to good health.

(2) Preventive Medical Services by well-staffed health departments, but medical care for the indigent through local facilities, with State or Federal aid when necessary.

(3) Adequate Maternity Care at a price the people can afford to pay, with State or Federal aid when necessary.

(4) Adequate Infant and Child Care by individual physicians or by welfare stations where need is shown.

(5) Health and Diagnostic Centers and Hospitals, utilizing present facilities to the utmost, and developing facilities where need is locally determined by processes provided for in the Hill-Burton Bill.

(6) Extension of Voluntary Prepaid Medical and Hospital Care Plans.

(7) Adequate Medical and Hospital Care for the Veteran, utilizing to the utmost the facilities of his own community.

(8) Research in the Medical Sciences in a national science foundation.

(9) Proper Development of National Philanthropic Health Agencies, such as the cancer, poliomyelitis, and tuberculosis organizations.

(10) Widespread Health Education on good health habits, and on the availability of health facilities.

* * *

At the bottom of the box is printed:

WE CONNECTICUT PHYSICIANS BELIEVE THAT IN THE PRESENT SYSTEM OF "FREE ENTERPRISE IN MEDICINE," WHICH HAS RESULTED IN THE FINEST MEDICAL SERVICE, THIS POSITIVE PROGRAM PROMISES FURTHER EVOLUTIONARY PROGRESS. IN SUBSEQUENT ISSUES, EACH PLANK IN THIS PROGRAM WILL BE ELABORATED.

* * *

Immediately beneath the box, appears:

Your predecessor, the horse-and-buggy doctor, was by all odds, the best public relations man of his day. You are his successor, and inherit his responsibility in behalf of modern organized medicine. In your daily contacts with your patients, tell them what organized medicine wants and why.

Connecticut State Medical Journal—The President's Page

In the April issue of the *Connecticut State Medical Journal*, Dr. Joseph H. Howard, president of the Connecticut State Medical Society, comments on President Truman's national health plan and related matters, as follows:

At the Conference of Presidents in Chicago last December, Dr. Altmeyer, Chairman of the Social Security Board, stated that at that moment thousands of people were dying because of lack of medical care. This was rather shocking to the physicians of Connecticut where no person dies because medical care is not available. If the condition exists, as Mr. Altmeyer states, something should be done about it. If there are areas in the United States where people die because there are no hospitals or doctors, it is time that these states developed a program for the improvement of medical care. This is a local problem. When proper hospital facilities are available, more physicians will settle in these areas.

The advocates of President Truman's plan would have the American people believe that the only thing lacking to make this a disease-free nation would be Socialized Medicine. Sidney M. Greenberg, M.D., in an article in the *C.I.O. News* of January 14, 1946, under the title of "Health Insurance Can Beat T.B." states that only ten per cent of the patients with tuberculosis are discovered early, and the solution to early diagnosis, treatment and cure of the other ninety per cent is the passage of the Wagner-Murray-Dingell bill. What absurd reasoning. If Dr. Greenberg has ever practiced medicine, he knows his statement is fantastic.

Rather recently it was noted that a number of cases of tuberculosis were being admitted to one of our State sanatoria from a particular housing development in an industrial community. The State Tuberculosis Commission was invited by the Health Officer to make a survey. Articles were published in the community newspaper. Door to door solicitation was carried on by the Air Raid Wardens to encourage each one of the five thousand residents to have a chest x-ray at a cost of one dollar, or without fee if they were unable to pay. In this development, only one hundred and eighty-six people reported for an x-ray of the chest. The others were not interested.

Does this new legislation have some method of driving people to the doctor? New laws will never change human nature. The American people still do what they please in matters of medical care. When properly informed, they will reject compulsion in health insurance.

Incorporation Papers Granted to Medical Care Organization Sponsored by American Medical Association

Broad Objectives of New National Nonprofit Group; Meeting Called to Study Operational Plans

The Secretary of State of Illinois has issued a certificate of incorporation to Associated Medical Care Plans, according to an announcement in the April 13 issue of *The Journal of the American Medical Association*.

The new corporation is a national nonprofit organization which will include all state and local medical care plans that comply with the minimum standards for medical care approved by the Council on Medical Service and Public Relations of the American Medical Association.

* * *

The Journal's announcement says:

The objects of the new corporation as set out in the articles of incorporation are broad. They embrace a variety of activities, which can be expanded as future experience and developments may indicate. Specifically, the authority granted by the state of Illinois permits the new corporation "to promote establishment and operation of such nonprofit, voluntary medical care plans throughout the United States and Canada as will adequately meet the health needs of the public and preserve and advance scientific medicine and the high quality of medical care rendered by the medical profession of the two countries." Significantly, the corporation recognizes that "state and local medical care plans should be autonomous in their operation so that the needs, facilities, resources and practices of their respective areas can be given due consideration, but that the health and welfare of the public is advanced by the coördination through the medium of this corporation of methods, coverages, operations and actuarial data."

* * *

The actual activities that are at present contemplated are indicated by the specific duties that the proposed by-laws impose on the commission of the corporation, which, in effect, is the corporation's board of directors. The commission is directed to undertake and promote:

(a) Research and compilation of statistics with special studies of experience and collection and distribution of financial and service data.

(b) Consultation and information services based on contacts with existing and contemplated plans concerning administrative policies and procedures, and the distribution of significant literature and information.

(c) Public education by interpreting the national scope and significance of the medical care plan movement under medical society auspices with publicity methods suitable to the various groups in the public and yet consonant with proper professional practices.

(d) Coördination and reciprocity among plans with reference to transference of subscribers and benefits in the development of national enrollment among large enterprises and authoritative contacts with governmental or national agencies such as Farm Security, welfare and industrial groups.

The necessary details dealing with the manner in which these duties will be performed are matters that will evolve from future meetings of the commission and of members of the corporation. To expedite the initiation of corporate activities, a meeting of the commission has been called for April 26 and 27 in Chicago from which will emerge considered operational plans. These will be presented for approval to the first meeting of the members of the corporation, now tentatively to be held in San Francisco the two days immediately preceding the annual session of the American Medical Association in July.

* * *

Among the more pressing matters of the agenda of the commission for its April meeting is acceptance of applications for membership and appointment of an executive director to administer the day by day activities of the corporation. Plans, at least temporarily, call for the establishment of an office, with necessary administrative and clerical staff, in the headquarters building of the American Medical Association, thus facilitating coördination of the activities of the new corporation and of the Council on Medical Service and Public Relations of the American Medical Association.

* * *

The following men are serving as indicated on an interim basis until the membership can elect officers at the corporation's first annual meeting:

President—F. E. Feierabend, M.D., of Surgical Care, Inc., Kansas City.

Vice-President—William M. Bowman, of the California Physicians' Service, San Francisco.

Treasurer—Norman M. Scott, M.D., of the Medical Service Plan of New Jersey, Clinton.

Secretary—Jay C. Ketchum, of the Michigan Medical Service, Detroit.

Commissioners—Willard C. Marshall, Oregon Physicians' Service, Portland; Edwin M. Kingery, Iowa Medical Services, Des Moines; Arthur J. Offerman, M.D., Nebraska Medical Service, Omaha; L. Howard Schriver, M.D., Ohio Medical Indemnity, Cincinnati; Lester H. Perry, Medical Service Association of Pennsylvania, Harrisburg; Herbert H. Bauckus, M.D., Council, Medical Society of State of New York, Buffalo; Raymond L. Zech, M.D., Seattle, Council on Medical Service and Public Relations of the American Medical Association; A. W. Adson, M.D., Rochester, Minn., Council on Medical Service and Public Relations of the A.M.A., and Edward J. McCormick, M.D., Toledo, Council on Medical Service and Public Relations of the A.M.A.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Wagner-Murray-Dingell Bill, S. 1606—Pro and Con Comment by a Washington Bureau

Washington, April 1.—Battle lines were drawn today for what promises to be a long and torrid debate on the first piece of basic social reform legislation to pop up here in many years—the national health act.

The act, perhaps better known as the Wagner-Murray-Dingell bill, comes up for a hearing tomorrow before the Senate Committee on Education and Labor. Propaganda guns on both sides soon will be making so much noise that it will be a wise citizen who can keep sight of the real issues.

A new weapon was wheeled into the firing line on the pro side of the controversy when the Committee for the Nation's Health organized to keep the public informed.

Already in position on the other side is the American Medical Association, which, the new committee charged, has set up the National Physicians committee to spend $400,000 a year to beat the Wagner-Murray-Dingell act.

One of the first acts of the new committee was to hear Rep. John M. Dingell, one of the fathers of the bill, declare the plan has wide support—particularly among the people of California.

That may come as a surprise to many members of the California State Legislature, where proposals for compulsory health insurance have met sudden death with the benefit of certain attending physicians.

Regardless of what the California Legislature thinks, Dingell declared, a California poll shows the people there want "the highest type of medical protection for the lowest possible cost.

"And they don't care whether you call it federalized medicine or socialized medicine; they want it," Dingell said. The poll, he added, was taken by a California physicians' group.

Among the famous personalities sponsoring the committee for the nation's health are these Californians: Atty. Gen. Robert W. Kenny, editor Chester Rowell of San Francisco and radio personalities Norman Corwin and Orson Welles.

Since the term "socialized medicine" is the handy but inaccurate label pasted on the plan by its opponents, the committee is searching for an effective piece of counter-propaganda.

One correspondent at today's session suggested the present doctoring system be dubbed "commercialized medicine."

But what the committee wants most of all to do is to sell the Wagner-Murray-Dingell bill by the simple expedient of telling the folks back home what the measure proposes to do.

Heading the committee is Channing Frothingham, a successful and non-political doctor from Boston, who says he and many other physicians think W.M.D. looks like a pretty good prescription.

Symptoms which the good doctor and his helpers say indicate the present medical system is not adequate include these:

In many rural areas there is only one doctor for every 3,000 persons; in many cities the ratio is one doctor for every 600 persons; doctors and hospitals seem to concentrate in areas where the money is, not where the sickness is.

About 15,000,000 Americans are without a recognized general hospital.

People with low incomes have more sickness and get less attention than those with high incomes.

Forty per cent of the men called by the draft were unfit.

In prewar days, 11 countries had lower infant mortality than the United States; 20 had lower death rates among people 35 to 64 years old.

Disease and sickness cost the American industrial machine 500,000,000 lost man days per year.

The remedies proposed in the national health act include these, among others:

A compulsory health insurance program costing 3 to 4 per cent of the individual's income up to $3,600 annually—split between the worker, the boss and the Federal Government, as in the present social security system.

Complete freedom for patients to choose doctors, and vice versa.

Expansion of preventive medicinal practices to every part of the country through grants to local health departments.

Fees to be set by doctors' committees in each state and administration to be managed by local committees.

Full medical care to veterans—who are now limited to service-connected disabilities—and their families.

Location of more doctors and more hospitals in rural areas.

Continuation of high fees for those who want and can afford luxury treatment; for the rest, insurance to pay their doctor and hospital bills.—Frank Rogers of "Daily News Washington Bureau" in Los Angeles *Daily News*, April 2.

United Public Health League Comment on S. 1606

April 9, 1946

Special Bulletin—410 Hill Building, 17th and I Streets, Washington, D.C.

Senate committee hearings on S-1606, the Murray-Wagner Bill, opened with a bang and developed a fist-shaking verbal brawl between Senators Murray and Taft. Senator Murray began the hearings of his Committee on Education and Labor on April 2nd with a statement in which he commented on an editorial in the Washington *Post* warning against condemning programs for health insurance as "communistic." Lauding the editorial, Murray stated that it offered "good advice to people not to be making charges that this measure is communistic."

"I consider it socialistic," Taft interposed. "It is in my mind the most socialistic measure ever considered by Congress." Murray insisted that Taft keep quiet and permit him to complete his introductory statement. Taft demanded the right to make a statement.

Murray stood up and shouted at Taft, but the latter refused to remain quiet. Murray threatened to call a policeman and have Taft thrown out of the meeting. Finally in disgust Taft arose, told the chairman (Murray) that he was not fit to preside over the Committee hearing and stalked out of the room, saying he would not return.

During this argument only one other Republican, Senator Alexander H. Smith of New Jersey, was present. Senators Murray and Wagner on the Democratic side were also present.

Senator Taft did get into the record the fact that he will present a national health bill of his own for a "comprehensive medical program" providing Federal aid to the states.

Senators Murray, Wagner, Thomas, Taft, Pepper, Smith, Fulbright and Morse were present at intervals during the hearings on the opening day, Senator Wagner being the only one, in addition to Chairman Murray, to remain for the entire session of 2½ hours. . . .

Re: S. 1606—Wagner-Murray-Dingell Bill

(COPY)

NATIONAL PHYSICIANS COMMITTEE

Chicago 2, Ill., April 9, 1946.

Hearings on S. 1606

On April 2 hearings on Senate Bill 1606 were begun. The following witnesses have appeared before the Committee during the first week of the hearing: Senator Robert F. Wagner, New York; Senator Claude Pepper, Florida; Congressman John D. Dingell, Michigan; Dr. J. W. Mountin, representing the Surgeon General of the United States Public Health Service; Watson B. Miller, Federal Administrator of the Federal Security Agency; Arthur J. Altmeyer, Chairman of the Social Security Board; Leo J. Linder, Chairman of the National Committee on Social Legislation of the National Lawyers Guild, and William Logan Martin, representing the American Bar Association.

Each of these witnesses was interrogated at length by members of the Committee, and each, in turn, filed a lengthy statement expressing the point of view of his group or agency. Summaries of the testimony and the statements will appear in current issues of the *Journal* of the American Medical Association.

On the first day of the hearings, immediately after Chairman Murray had opened the session, Senator Robert Taft, Ohio, requested permission of the Chairman to make a statement. Permission was refused, and there followed a very heated discussion between Senators Taft and Murray.

Notable incidents which occurred during the hearings were the intelligent and thought-provoking questions and statements by Senators Ellender, Louisiana; Donnell, Missouri, and Aiken, Vermont.

Prelude to Hearings

In the March 29 issue of *PM*, leftist New York City daily newspaper, the major portion of two pages was used to villify the efforts of the medical profession—and particularly the work of the National Physicians Committee—to preserve for the people of this nation our present system of medical care. The *PM* tirade is interesting and pertinent because it provided the propaganda background for the Committee hearings and evidence that the radical, leftist forces recognize the scope and effectiveness of the N.P.C. program. . . .

In our Informational Bulletin No. 3 we quoted the full text of the form letter which Senator Murray has sent to most of the State and County Medical Societies which had requested the privilege of testifying before the Committee. It was also suggested that medical societies prepare statements for filing with the Committee after the principal witnesses who favor this legislation have been heard.

Witnesses from State and Local Medical Societies

On Wednesday, April 3, it was learned that Chairman Murray had appointed a Sub-Committee composed of Senators Fulbright, Arkansas; Smith, New Jersey, and Morse, Oregon, to review the large number of applications that the Committee has received from other than national organizations. This Committee has been instructed by the Chairman to report to the Whole Committee those organizations at the state and local level who should be invited to present witnesses. There is no indication at this time what the action of the Fulbright Sub-Committee will be; however, on Thursday, April 4, responding to a comment by Senator Donnell, Chairman Murray said:

"I am sure that we will have that (the point of view of organized medicine) during the course of the hearings, and I suppose that we will have representatives of the

American Medical Association here, and they have already indicated their intention to be here, and the representatives from several of the State organizations will be here."

In the light of Fulbright Sub-Committee activities and Chairman Murray's statement, it would seem most important that State and Local Medical Societies continue and intensify their efforts to present witnesses before the Committee.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

U. C. Testimonial Banquet to Its Service Men

In San Francisco, on the evening of April 25, 1946, at the Palace Hotel, University of California Medical School alumni and staff members met at banquet, in honor of their returning military fellows.

If possible, text of some of the addresses will be secured for presentation in CALIFORNIA AND WESTERN MEDICINE.

Program of the evening follows:

Program

National Anthem............................Orchestra
Toast to Servicemen.........Dean Francis Scott Smyth
Toastmaster
Response..........Col. Gordon E. Hein, For the Army
Capt. Clark M. Johnson, For the Navy

⁂

Dinner

Memorial..............Emeritus Dean Langley Porter
Welcome Home, Confreres...............Dean Smyth
Pictorial ....Philip H. Arnot
Welcome Home, Californians, His Excellency,
The Governor of California, Earl G. Warren
Address...Major General Paul R. Hawley, Medical Department, United States Veterans' Administration

All Hail, Blue and Gold

Condition of German Medical Schools: Their Condition Very Poor: So States Dean of Duke University School of Medicine

Information has been made available concerning the German medical schools which was gathered by Dr. Wilburt C. Davison, dean of the Duke School of Medicine, on his trip abroad last summer.

Conditions in the German hospitals and universities which teach medicine, according to Dr. Davison, were poor. Of the seven schools in the United States zone of occupation, only three were physically intact at the time of Dr. Davison's observation. These were the schools at Marburg, Heidelberg and Erlangen. The other four, those at Giessen, Frankfort, Munich and Wurzburg, had improvised usable accommodations for the hospital care of patients in their communities, but their facilities for teaching were inadequate.

Of the German medical schools, Dr. Davison had this to say: "The German medical schools, which were good in 1912, have not kept pace with the advances in medicine. Except for an occasional specialist who has become famous, the German graduates, even those who took postgraduate work as assistants, are not equal to the average American senior medical student.

Inadequate Laboratory

"The reasons are lectures without adequate laboratory and clinical work, too many students with little or no selection, inadequate facilities, and faculties which are too small, the members of which do not know modern non-German medicine, whose salaries depend on the number of their students so that they are tempted to encourage an increased enrollment, who also examine their own students and thus may lower standards, and who have too much private practice. Futhermore, the separation of research workers from the medical schools into Kaiser Wilhelm institutes has reduced the productiveness of German medicine so that the medical journals for a generation have been of little scientific value.

"Unfortunately, most of the Germans do not realize that improvement, reorganization, limitation and supervision of medical education are necessary. As a result, although accurate figures are not available, German physicians, in addition to being poorly trained, are too numerous. The early opening of the medical schools is unnecessary to supply more physicians, but it is desirable in order to maintain continuity of medical education. The German medical schools should be a warning to us not to let our pride in American medical education reach the point at which we are completely satisfied and are unwilling to try to improve it."

Three programs were suggested for the opening of the medical schools in Germany: (1) limited denazification without reform, the removal of only those individuals arrested under orders of AMG or removed by action of the present faculty or its planning committee; (2) complete denazification and reform with active American participation, selection of the students, reorganization of the cirriculum and active participation by American medical schools in the German medical school revamped program; and (3) the complete denazification of the medical faculties without reorganization or reform of the medical curriculum, except for the elimination of Nazi ideology and dangerous research activities.

In Dr. Davison's opinion, the last of these programs is the most practical one. Complete denazification removes about 50 per cent of the existing faculties and staffs from the schools although it leaves the Germans faced with the problem of gathering adequate personnel and maintaining the standards of medical education. This is in accord with the AMG principle of making the Germans work out their own problems. Two of the medical schools were able to conduct postgraduate courses with a denazified staff and were able to open in November, 1945, with regular medical semesters.—Durham, N. C., *Morning Herald*.

COMMITTEE ON MEDICAL DEFENSE

On Charges of Manslaughter

An Editorial in The Bulletin *of the Los Angeles County Medical Association of March 7, 1946, by Louis J. Regan, M.D., President of the Los Angeles County Medical Association*

In an article elsewhere in this issue of *The Bulletin* there appears a report which presents a fair extract and outline of the case of People v. Edward Albarian and June Coleman.

Messrs. Richard L. Kirtland and Wm. W. Vaughn, who represented Dr. Albarian, and Mr. Harry Duckett, who represented Miss June Coleman, deserve not only congratulations but also the highest commendation for the meticulous preparation and the skillful presentation of this important case.

This case merits the thoughtful consideration of every physician in California. Had a conviction resulted on the trial, the practice of medicine in this State must have been radically affected thereby, as will inevitably occur when and if any physician is convicted of manslaughter on the grounds that, although engaged in an act lawful in itself, he failed to act "with due care and circumspection" in his professional care of a patient as the result of which the patient died.

In considering this problem generally, the potentiality of one type of case immediately comes to mind. There are many reported instances of foreign bodies, metallic and other, having been left in the abdomen following abdominal surgery. No one would reasonably maintain that such an occurrence resulted due to anything other than inadvertence. Further, could anyone reasonably maintain, in the present state of human development and medical practice, that he could or would guarantee that no foreign substance will ever be left in a body cavity following surgery? What then if a surgeon must, under peril of criminal prosecution, see to it that no foreign substance is ever inadvertently left in the body of a patient? (It being understood, of course, that criminal prosecution for manslaughter could not result except when it is claimed that the patient died as the result of the allegedly negligent act.)

If, after Dr. X does an abdominal operation, his patient dies of intestinal obstruction, due to a loop of bowel being caught in the handle of a hemostat left in the abdominal cavity after closure and thereafter and thereon Dr. X is convicted of manslaughter, will not Dr. A or Dr. B or Dr. C be likely candidates for successful prosecution on an analyagous set of facts?

It would be a very happy situation if the degree of negligence required in California to support a conviction in the type of case under consideration were "gross," "wanton," "willful," but such is not the case. In the case of People v. Albarian and Coleman, the prosecution argued not only that ordinary negligence was sufficient to justify the jury in finding a verdict of "guilty," but that doctors, since they are instrumentalities dangerous in themselves, and their patients are not in a position to protect themselves, must be held to a higher standard of care than other people.

It has been previously pointed out and is now strongly reaffirmed that the malpractice trend in California is alarming and vicious. The community has become pretty generally conditioned to the situation, to the great injury of medical prestige and to the great distress of the many physicians who individually become targets for malpractice accusations.

It is the duty of the medical profession to destroy the malpractice "racket," not because of what the profession itself is thereby suffering, but because of the injury to the public generally. The standards of practice tend to be deleteriously affected by the multitude of unjustifiable malpractice claims.

It can be declared as an unquestionable fact that the attitude of the profession toward honest malpractice claims has been and is an eminently fair one. The medical group not only approves the reasonable compensating of any patient injured through the ignorance or negligence of his medical attendant, but is striving continuously to raise standards of medical practice and to eliminate the unqualified and careless practitioner.

The malpractice situation in this community is a miserable one. All of our efforts up to this time have failed to improve the picture materially. It is crystal clear, however, that it is solely and completely our job. Any legal steps to accomplish the desired end should be taken.

LOUIS J. REGAN, M.D.

* * *

Information: Manslaughter

The People of the State of California v. Edward Albarian and June Coleman

On October 6, 1945, Dr. Edward Albarian, D.O. and June Coleman, R.N., were accused of manslaughter by a complaint filed in the District Attorney's office of Los Angeles County. After a three-weeks' trial and on February 6, 1946, the jury in Judge Clement D. Nye's court returned a verdict of not guilty as to both defendants.

Messrs. Richard L. Kirtland, of the law firm of Reed and Kirtland, and William W. Vaughn, of the firm of Maddox & Vaughn, represented Dr. Edward Albarian. The nurse, June Coleman, was represented by Mr. Harry Duckett, of the firm of Spray, Davis & Gould.

This case was of unusual interest to both the medical and legal professions since it is the first time in Los Angeles, insofar as is known, that a physician or nurse has ever been accused of manslaughter, a felony, arising out of the death of a patient undergoing treatment when admittedly the defendants were not at the time engaged in any unlawful act.

Defining Manslaughter

Involuntary manslaughter is the killing of a human being in the commission of an unlawful act . . . or in the commission of a lawful act which might produce death without due caution and circumspection. In previous prosecutions under this statute the accused was at the time allegedly engaged in an unlawful act as the result of which the death occurred. These prosecutions arose out of two general classifications—one, while in the performance of an illegal abortion, and two, while attempting to treat by a method for which the accused was not licensed. An example of the latter is where a naturopath attempted surgery as a result of which the patient died due to ignorance and negligence in the surgery.

In the instant case it was not contended that the defendants were engaged in any unlawful act, but merely that in the performance of a lawful duty (lawful practice of their professions), they committed an act which might cause death (disputed), and which did cause death (disputed), and in so doing acted without due caution and circumspection—or negligently (disputed).

Had They Been Convicted

Had these defendants been convicted no physician or nurse could have any reasonable assurance that they would not be prosecuted and possibly convicted in any case being treated where death resulted, if it could be established that they had been negligent in any degree in the treatment. In short, every death case occurring during treatment would be a potential manslaughter case.

Dr. Edward Alharian and Nurse June Coleman were, respectively, an interne and a nurse in the Los Angeles County General Hospital. Pauline Estrada, a 14-year-old Mexican girl, was brought to the hospital on October 6, 1945, with a condition diagnosed in the admitting room as "acute appendicitis and probable ruptured appendix." She was scheduled for emergency surgery and orders given for 1,000 cc. of normal saline i.v. preoperatively. Nurse June Coleman took a liter bottle off a cupboard supposed to contain only hypertonic solutions of concentrated strengths of less than 10 per cent. She read the label as "Physological Salt Solution." After preparing an intravenous set-up she placed the bottle at the bedside of the patient, awaiting the arrival of Dr. Albarian, who was to give the intravenous solution. Dr. Albarian walked into the room, looked at the bottle, read the label as "Sodium Chloride 2 per cent," and started the intravenous injection. Nurse Coleman came into the room, observed that the intravenous had been started, and left to get a clamp at Dr. Albarian's order. After the clamp was applied both Dr. Albarian and the nurse left the room and did not thereafter see her during her lifetime.

The Autopsy Report

One hour and 45 minutes later an attendant on the ward reported to the head nurse that the patient's condition was not good, whereupon a resident physician was called who attempted heroic measures to revive the patient, without avail. More careful observation of the label disclosed that the solution was 20 per cent sodium chloride and that approximately 350 to 550 cc. had been given.

The autopsy surgeon, Dr. Frank R. Webb, reported the cause of death as "hematolysis due to strong saline solution due to acute appendicitis with ruptured appendix." Rfter a Coroner's inquest, the District Attorney issued an information charging the two defendants with manslaughter.

From the time of the autopsy surgeon's report, local newspapers gave much attention to the story, which was labeled "Wrong Bottle Case."

* * *

In the trial of the case the People contended that the defendant, Dr. Alharian, acted without due caution and circumspection in that he did not check the bedside chart (which admittedly was not at the bedside), and had he done so he could have seen that a normal saline solution was ordered and not 20 per cent, as given, and not 2 per cent, as he intended to give; and in reading the label as 2 per cent, where careful observation would have shown that the label read 20 per cent.

As to Nurse Coleman, it was contended that she had acted without due caution and circumspection in not closely observing the label and ascertaining that it contained 20 per cent sodium chloride and not physiological salt solution, as she alleged; and as to both defendants, it was urged that the solution killed the girl.

Generalized Peritonitis

The defense contended that Dr. Albarian had acted with due care and circumspection, since (1) the label on the bottle was so poorly stamped that it more closely resembled 2 per cent than 20 per cent; (2) that the bottle was a stock solution not to be taken from the pharmacy, and should not have been on the ward; (3) that it was placed in a cupboard where no solutions were permitted other than hypertonic solutions of less than 10 per cent concentrated strength; (4) that concentrated solutions were not supposed to be kept in liter bottles; and (5) that it had not been the custom under war conditions in the County Hospital for the interne to check the bedside charts before giving intravenous medications. It was also contended that the girl died from overwhelming sepsis due to generalized peritonitis and septicemia.

Nurse Coleman maintained that she had checked the label before preparing the set-up and that it read "Physiological Salt Solution," and that she did not know how the 20 per cent sodium chloride bottle got on the bedside stand while she was out of the room, and that she was not present, as was the custom, when the intravenous was started, at which time it was customary to finally check the label on the bottle with the interne who would administer it.

At the preliminary hearing the autopsy surgeon maintained that 20 per cent sodium chloride in any amount was a lethal dose, and that 10 per cent, 5 per cent, 2 per cent, or any other concentration greater than .85 per cent could not be "safely given." He likewise testified that the 20 per cent saline solution caused hematolysis—"a disintegration of the red blood cells," which in turn caused the patient's death.

Evidence of Infection

At the trial the autopsy surgeon admitted that the organs, when observed grossly, disclosed various conditions which were consistent with sepsis. It wac likewise admitted that tissue slides demonstrated a septic spleen, myocarditis, and other conditions consistent with septicemia. But the autopsy surgeon contended that even though there was evidence of sepsis and septicemia, the appendix had probably ruptured after death (on autopsy), and that the peritonitis, if any, was local and not general, and, therefore, had "not progressed to the point where it would cause death." At the same time he insisted that death was due to the "strong saline solution," though admitting that he had read that sodium chloride had been given in some cases (ileus and wet brain cases), in amounts up to 300 cc. and in strengths up to 30 per cent.

An outstanding scientist in this community, a professor of pharmacology and toxicology at the University of Southern California School of Medicine, exhibited the autopsy surgeon's slides in the court room by a micro projector, and showed that in the tissue slides of each organ there was marked evidence of infection. A slide taken of the peritoneal fluid was interpreted as showing "a considerable quantity of mixed bacteria, including streptococcus viridans," and concluded that general peritonitis was present for some hours before death. He further concluded that on the basis of animal experimental work it was his opinion that death was due to overwhelming septicemia and peritonitis due to a ruptured appendix.

The autopsy surgeon testified on the preliminary hearing that slides taken of the blood showed complete hemotolysis. The pahrmacologist and toxicologist reported that the Wright stain slide and the H & E slide showed no hemolysis and only slight crenation.

Two pathologists connected with the Coroner's office testified that they were present when the autopsy surgeon performed the post mortem, and testified that they observed nohing, grossly or microscopically, that indicated hemolysis or any other condition resulting from a "strong saline solution," and on the other hand observed clear evidence of sepsis and general peritonitis, and attributed death to that cause.

Testimony Re Percentages

An outstanding physiologist at the Los Angeles College of Osteopathic Physicians and Surgeons, testified that as a result of animal experimental work done in the college laboratory he had ascertained: (1) That 20 per cent sodium chloride in equivalent amounts (or double amounts) did not cause death or other harmful effects; (2) that it most assuredly did not cause hemolysis and only slight crenation; (3) that the results were the same in normal animals and peritonized animals, and that all infected animals had lived through and after the infusions except the peritonized animals, and that the infused peritonized animals lived longer than the non-infused peritonized animals; (4) that all deaths occurring in the experiments were due to peritonitis and not to any saline solution.

Three well known surgeons testified regarding their personal experience with 20 per cent and 30 per cent sodium chloride solutions in amounts to 300 ccs. and other hypertonic solutions in strengths to 50 per cent, and in various amounts. To a hypothetical question which assumed facts similar to this case (including the fact that the deceased had from time of birth been in the same hospital 96 times for numerous infectious and contagious diseases), concluded that death was due to "septicemia due to general peritonitis from acute appendicitis and ruptured appendix."

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In polling the jury after verdict (reached within one hour of deliberations), they gave the following reasons for their decision:

(1) That the autopsy surgeon did not know what he was talking about and was evasive to questions on cross-examination.

(2) That the bottle was so poorly labeled that the misreading of the label was understandable and did not constitute negligence.

(3) That the error, if any, was due to the "higher-ups" in the hospital and to "pressure of business," and overwork under war conditions.

(4) That there was at least a reasonable doubt whether the death was due to the saline solution or the septicemia.

The District Attorney, in his closing argument, stated that the osteopaths and the medics were, for the purposes of this case, on a "honeymoon," but that "divorce proceedings" would be filed as soon as the case ended.—*The Bulletin* of the Los Angeles County Medical Association.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Veterans' Administration Medical Plan
183 Hospitals (151,500 Beds) by 1948

The Veterans' Administration is getting underway on a three-point hospitalization program. General Omar N. Bradley, Administrator of Veterans' Affairs, says it should give ex-servicemen and women medical care "second to none."

The three points of the program are:

1. Immediate construction of $448,000,000 worth of new hospitals (80 of them) and additions to several present ones.

2. A drive to staff V.A. hospitals with the best doctors in the country.

3. An arrangement with state medical groups to give veterans with service-connected disabilities treatment in their home towns by their own private doctors and hospitals.

Congress Appropriation

Plans drawn up and in some cases already working are largely the result of Dr. (formerly Major General) Paul R. Hawley's conception of what the veteran should get. Hawley is chief of V.A.'s new Department of Medicine and Surgery.

Congress has authorized the $448,000,000, but has actually appropriated only $300,000,000. V.A. says it is confident the remaining $148,000,000 will be appropriated this year and that the entire construction program will be completed by mid-1948.

V.A. now owns 103 hospitals, valued at $227,000,000. They house 95,000,000 patients.

In the meantime, 5,200 beds in Army and Navy hospitals are filled with veterans. In addition, V.A. has acquired 21 Army and Navy hospitals, some of which will become permanent V.A. property. A few thousand V.A. patients are housed in other public and private hospitals.

But it's not only brick and masonry that V.A. must have to handle the health of possibly 20,000,000 veterans. Dr. Hawley says he means to see that his hospitals are staffed with the best doctors in the country.

He explains that's one reason he is insisting V.A. hospitals go up in populated areas near medical centers. Opposition to Hawley's desire to locate hospitals where he thinks they will do the most good has been heard on various sides. But Hawley, backed by General Bradley, is sticking hard by his decision.

Medical Schools

He has enlisted the aid of almost all of the country's 77 Class-A medical schools. The setup worked out between V.A. and the schools of medicine calls for the training of V.A. doctors as specialists and for the loan of outstanding civilian doctors to V.A. as part-time consultants.

A new law also allows V.A. to hire competent physicians and surgeons at good salaries and to offer them opportunity for advancement. Previously, all V.A. doctors were Civil Service employees, bound to seniority rules.

Indication this law will give V.A. the pick of some of the finest doctors in the country is found in the increase of job applications to V.A. by doctors both in and out of armed forces. Fifty applications are received daily at the V.A. central office in Washington from nurses, doctors and dentists. Branch offices, too, are receiving applications.

During the last six months of 1945 only 600 doctors and nurses were hired by V.A. So far this year more than 2,500 have been added to V.A. payrolls.

Dr. Hawley says he expects applications to keep increasing and that in 1948 he will head a staff large enough to man 151,500 beds in 183 hospitals.

Treatment at Home

V.A.'s efforts to ease the burden on its own hospitals by allowing veterans with service-connected disabilities to get treatment at their own private hospitals and from their own home-town doctors is almost revolutionary.

Contracts already signed with state medical societies of seven states provide disabled veterans may get "out-patient" treatment from any private physician who is a member of the society. The doctor bills his society, and the society bills V.A. (A similar, but limited program, has long been a part of V.A.'s medical setup.)

The "home-town" medical care program was recommended by Bernard Baruch in a report requested by General Bradley last August.

California, New Jersey, Michigan, Kansas, Washington, Oregon and North Carolina are the states which have the program.

The California Physicians' Service, which has taken over the job, says it expects virtually 100 per cent cooperation from its 6,100 members.

Only veterans who have service-connected disabilities are eligible to participate in this out-patient plan.

Veterans with non-service-connected disabilities are eligible for free hospitalization, however, provided two conditions are met :(1) They must sign a statement saying they are "financially unable" to pay for the treatment they need, (2) there must be room for them in a V.A. hospital.

The bulk of the 151,500 beds V.A. expects to have in 1948 will be filled with non-service-connected cases. Even today non-service cases far outnumber service-connected.—San Francisco *Chronicle,* March 31.

General Bradley Promises California 13,000 Veteran Hospital Beds

A threefold expansion of beds in California veterans' hospitals by 1950 was recently promised the State's House delegation by General Omar N. Bradley, Veterans' Administrator.

General Bradley answered the protest of California Congressmen that the 4,491 beds in the State's veterans' hospitals now are insufficient with a promise of 13,000 beds by 1950.

He said, however, shortages of doctors and nurses would hamper immediate expansion of medical facilities for veterans. One factor in the shortage is the need of caring for both veterans injured in combat and those suffering from non-combat ailments.

Veterans Administration to Build New Hospitals

The Veterans' Administration recently announced it has turned over to Army engineers plans for the construction of new medical units at Fresno and San Fernando and Phoenix, Arizona, costing $6,596,219. A 250-bed hospital at Fresno and a 150-bed tuberculosis addition is planned at San Fernando.

The Veterans' Administration also ordered a speedup of hospital construction in Los Angeles planned to include several new buildings costing $1,998,892.

Lieut. Governor Houser on Blue Cross Plan Board

Lieut. Governor Fred Houser was elected to the board of directors of the Southern California Blue Cross Plan at its annual meeting, held in Los Angeles recently, according to Ralph Walker, executive director.

Mr. Houser was elected for a two-year term to fill an existing vacancy.

Elected for three-year terms were T. E. Ivey, Jr., vice-president of California Bank; Jess V. Buck, superintendent of Murphy Memorial Hospital, Whittier; Dr. J. J. Crane, past president of Los Angeles County Medical Society; Howard Burrell, attorney; Dr. Glenn E. Meyers, and J. Howard Ziemann, attorney.

According to Walker, membership in Blue Cross increased 44 per cent during 1945 and he predicted that twice that amount would be enrolled during 1946.

At the end of the year there were 155,412 Blue Cross members in the southern area, and a total of $2,700,000 had been paid by the plan for members' hospital care, according to Mr. Walker.

Mental Hospitals of California Need Doctors and Attendants

Three hundred hospital attendants and 30 physicians and surgeons are needed to fill vacant positions in ten California mental hospitals, the State Personnel Board recently announced.

Starting salary for hospital attendant is $140 a month. Physicians and surgeons are paid $300 a month, plus maintenance for self and family valued at $113. The latter live on the institution grounds, but hospital attendants usually do not.

California Will Survey Need for Hospitals

California's hospital needs will be surveyed by an advisory council named by Governor Warren. In announcing the appointments, Warren expressed belief that on the basis of a population of approximately 9,000,000 people the State should have 12,000 to 15,000 additional beds.

"We must remedy this situation before disaster strikes us," he said. "In many rural areas hospitals and health center facilities are now totally lacking."

The council will work under Dr. F. K. Gilman, San Francisco.

The Warren appointees are: George Wood, superintendent Peralta Hospital, Oakland; Frank Booth, San Luis Obispo; Dr. J. A. Katzive, superintendent Mount Zion Hospital, San Francisco; Dr. C. Glen Curtis, Brea; Dr. Anthony J. Rourke, superintendent Stanford University School of Medicine, San Francisco; Dr. H. M. Ginsburg, medical superintendent, Fresno County; Dr. John Sippy, director of San Joaquin County Local Health District, Stockton; Dr. Forest Cuninan, Monte Sano Osteopathic Hospital, Los Angeles; Mrs. Gabriel Mulvane, San Bernardino County Hospital; Rt. Reverend Monsignor Thomas J. O'Dwyer, Los Angeles; Max Silverstein, Los Angeles; Clarence A. Romeyn, Los Angeles; T. C. Allen, Hanford; Mrs. Anna Thuesen, San Francisco, and Lawrence Oliver, San Diego.

Mt. Zion Hospital Reveals $3,000,000 Expansion Plan

Mt. Zion Hospital of San Francisco, is planning a three-million-dollar expansion program expected to make the institution one of the most modern medical centers on the West Coast.

The hospital has purchased additional property on the block bounded by Divisadero, Scott, Post and Sutter streets, owning all but the two corners on Sutter St.

Dr. J. A. Katzive, director of the present Mt. Zion Hospital at Post and Scott Sts., said the new proposed eight-story building will increase the capacity to 350 beds from the present overcrowded facilities which can care for only 163 patients.

In addition to the new building, it is hoped that an apartment house on Scott St. and two other private buildings can be converted into medical units for doctors' offices.

Although separate from Mt. Zion, a nonprofit organization, the new Maimonides Health Center—for which a $600,000 drive has just been completed—will also be an important part of the new hospital's operations.

This center, which will provide care for the chronically sick, will use laboratory facilities and staff of Mt. Zion, will be built across the street on Sutter St. from the proposed addition, and it is hoped will ultimately be connected to the main building by a tunnel.

The three-million-dollar campaign fund has the approval of the Community Chest, of which the hospital is an agency.

Timothy Pflueger is working on preliminary plans for the new center.

Lutherans Mark Gains of California Hospital in Los Angeles

Representatives from 220 Lutheran churches in Southern California recently celebrated the 25th anniversary of the Lutheran Hospital Society at Our Savior's Lutheran Church.

Dr. Julius Lincoln, pastor of Trinity Lutheran Church, Chicago, reviewed the history of the society from 25 years ago when he was first vice-president and the treasury had $26 to the present organization which boasts buildings, equipment and other assets worth $3,000,000.

Dr. William H. Olds, chairman of the medical staff at the California Hospital, announced the hospital has inaugurated specialty training in surgery, obstetrics and urology. Ritz E. Heerman, hospital superintendent, described plans for adding 150 beds to the hospital.

Fritz C. Noel, society chairman, presided and presented 100 student nurses who attended in uniform, and the Lutheran Choral Union directed by Arthur W. Wolf.

COMMITTEE ON HISTORY

History Renascent

In *The Bulletin* of the Los Angeles County Medical Association for April 18, 1946, under the above caption Editor E. T. Remmen calls attention to the new publication, *"Journal of the History of Medicine,"* adding thereto interesting comment. Editorial follows:

The past hundred years has witnessed an accumulation of sound scientific data entirely unprecedented in the annals of mankind. Investigative and experimental techniques have almost entirely replaced the philosophic, argumentative and traditional approaches which hampered progress during so many weary centuries. It is not remarkable that modern workers, including physicians, have been so dazzled by the brilliance of their accomplishments and so well satisfied with the success of their own methods, that they have paid scant attention to accounts of the struggles of scientists throughout the ages to explain natural phenomena,—scientists who did not have the microscopes, chemical knowledge and electrical aids which are taken for granted by today's researchers.

Man constantly seeks to orient himself and is dissatisfied if he fails. To be lost on ocean or trackless prairie, to be uncertain as to the day or hour, to be unaware of the manner in which a result was obtained, is to be acutely uncomfortable. One cannot truly consider himself to be in possession of a scientific fact unless he knows the errors and successes which led to the establishment of that fact. It is gratifying, therefore, to note the current revival of interest in the history of medicine.

The first issue of the *Journal of the History of Medicine,* to be published quarterly by Henry Schuman, New York City, and edited by George Rosen, is a most worthy contribution to this field and one which augurs a brilliant future for the publication. There is a distinguished board of consulting editors, representing many of the important medical centers here and abroad. The *Journal* is the second publication in this field in the United States, the other being the *Bulletin of the History of Medicine* edited by Dr. Henry E. Sigerist. It is the announced purpose of the *Journal* to present studies which will be of interest to as large a section of the medical profession as possible. The *Journal* will not publish bibliographies nor studies of a technical or philological character, feeling that the *Bulletin* is the proper medium for studies of that nature. It will therefore serve to supplement the *Bulletin.* Contributions are sought on all aspects of the history of medicine, including public health, dentistry, nursing, pharmacy, veterinary medicine and the various sciences that impinge on medicine. Papers dealing with limited and specific subjects are sought, as well as articles of wider scope summarizing important fields and outlining broad trends.

The first article in the new publication is by Charles Singer, M.D., and is entitled, "Some Galenic and Animal Sources of Vesalius." Dr. Singer shows the manner in which the ancient physiologic teachings of Galen warped and twisted Vesalius concepts of anatomy. Galen taught that the basic principle of life is a spirit, or pneuma, drawn into the body in the act of respiration from the general world-soul or world-pneuma. This world-pneuma enters the body through the trachea or "rough artery," passes to the lungs and thence through the pulmonary veins to the left ventricle. Nutriment, absorbed by the portal system from the intestine, is carried to the liver where it is elaborated into venous blood, imbued with the spirit which is innate in all living substances, and distributed to all parts of the body through the vena cava and the systemic veins. The liver, as the source of all veins, is the first key to Galenic physiology.

In the region of the heart the vena cava gives off its largest branch, a blind diverticulum (the right side of the heart). Blood entering this diverticulum may have one of two fates. It may remain awhile in the ventricle, giving up impurities which are carried to the lung by the pulmonary artery and exhaled. The purified blood then ebbs back into the veins. Another smaller portion of the blood trickles through imaginary channels in the interventricular septum to the left ventricle, carrying the natural spirit derived from the liver. There it receives the pneuma from the outer world which arrived via the pulmonary veins from the lungs. The higher form of spirit thus elaborated is distributed through the arteries to the body in general. This is the second key to Galenic physiology.

Blood containing the vital spirit ascends to the brain through the carotids, the "soporal or apoplectic arteries of Vesalius," which divide at the base of the brain to form the "marvelous network" or rete mirabile, (actually non-existent in man), where the vital spirit is changed into the third, or highest and most subtle type of spirit, the animal spirit. This elusive substance enters the brain and is distributed to all parts of the body through the nerves, which contain minute channels. This is the third key.

To have questioned the teaching of Galen in the sixteenth century would have been unthinkable. That Vesalius was able to reconcile his first-hand knowledge of anatomy, obtained from animal dissection and to a lesser extent from human dissection, with an ancient set of physiological misconceptions, is not much more remarkable than some of our own slavish adherence to tradition in the face of contradicting scientific evidence. Witness the frequency with which old fallacies are transmitted by one textbook writer to another, despite abundant experience to the contrary.

The study of the history of medicine is not a pastime for dotards alone. Nor should it be undertaken with the supercilious attitude that we are today too enlightened to commit the stupid errors of the past. The work of bygone scientists should be approached with humility and with an effort to view their problems in the light of the information and techniques then available. The student, having observed how barriers to progress have been created by closed mental doors, may thus gain some hope of keeping his own intellectual apertures unobstructed by preformed concepts.

COMMITTEE ON SCIENTIFIC WORK

George Dock Lecture

The annual George Dock Lecture of the Barlow Society for the History of Medicine will be given by Dr. Donald Frick, at a joint meeting with the Los Angeles County Medical Association, Thursday, April 4th, at 8 p.m., in the Lounge of the Association.

Dr. Frick's subject will be: *"Carlos Finlay and Yellow Fever."*

Members of the Association are cordially invited to bring guests.

U.S.C. Graduate Course in Cardiovascular Diseases

University of Southern California School of Medicine—Graduate Division, announces a Graduate Course in the Cardiovascular Diseases on each Monday evening, for 12 weeks. George C. Griffith, M.D., will present the clinical aspects and management of cardiovascular disease. Evenings—8:00 to 10:00 p.m. Beginning April 22, 1946, Tuition $35.00. Registration fee $5.00. Direct all inquiries to Director, Graduate Division, School of Medicine, University of Southern California, Los Angeles County Hospital, Room 2721.

Animal Experimentation—Recent New York Battle

Another fight between the forces of medical science and the antivivisectionists has gone down into history with victory on the side of medical progress.

The DiCostanzo-Crews and the Van Duzer-DiCostanzo Bills, the double threat to medical research, were killed in committee on March 14 in the New York State Legislature after one of the most bitter battles ever fought on this question.

There is no doubt that victory was due to the close coöperation of the medical profession with many community groups interested in human health and welfare. This was done by means of the new organization, "Friends of Medical Research," sponsored jointly by the Medical Society of the State of New York and the New York Academy of Medicine, and conducted as a project of the Public Relations Bureau of the State Society.

Coöperation given in this legislative campaign has been remarkable. Medical students and faculties, newspapers, radio stations, scientific organizations, schools, official and unofficial public health agencies all pitched in to make the legislative campaign the occasion for wide popular education.

* * *

The winding-up week of the campaign was marked by several outstanding events. The *New York Times* featured the vivisection issue March 19 in its weekly program on WQXR entitled "What's On Your Mind." Elsa Maxwell and Lambert Fairchild took up the cudgels for the antivivisection forces; two outstanding medical scientists, Dr. Ephraim Shorr of Cornell Medical School, and Dr. Magnus I. Gregersen of Columbia College of Physicians and Surgeons, took the stand for animal experimentation. There was no question as to which side made the more convincing presentation. Representatives of the *New York Times* say that of the many letters stimulated by the program, the majority were "for" animal research. The broadcasting studio was filled to overflowing for both the program and the question-and-answer period following. Irene Castle McLaughlin, famed leader of the antivivisection clique, graced the occasion with her presence and after the program spent considerable time hobnobbing with the vivisection group.

San Quentin Convicts Offer to Undergo Fever Tests

Twenty-five California San Quentin Penitentiary convicts have offered to do battle against that most virulent scourge of childhood—rheumatic fever.

The 25 prisoners volunteered to be injected with streptococcus virus to determine whether immunity to so-called "strep" infections could be attained through use of vaccines, Dr. Leo L. Stanley announced yesterday.

The research project is being undertaken by Dr. Lowell Rantz, assistant professor of medicine at Stanford University Medical School, who has spent years of research on rheumatic heart disease.

Dr. Rantz said it has been generally accepted that rheumatic fever usually results from streptococcic infections, and medical science is confronted with the problem of preventing rather than curing the disease.

Should the San Quentin project show a measure of immunity can be built in individuals through injections administered in a reasonable period of time, then, Dr. Rantz said, "we can consider prevention of streptococcic infections and perhaps rheumatic fever through use of vaccines."

Dr. Rantz said the 25 San Quentin prisoners who volunteered as guinea pigs after a call was issued through the San Quentin *News*, will be given non-poisonous amounts of streptococcus bacillus weekly for from three to six weeks.

At conclusion of this period, he said, specimens of blood from each volunteer will be examined to determine whether sufficient anti-bodies have been created to render the individuals immune.

If these antibodies are present in sufficient number to indicate immunity, Dr. Rantz continued, then it will be assumed the individuals are protected from strep infections for a short period of time and yearly innoculations may be given.

Dr. Rantz emphasized that the San Quentin volunteers will have less reaction from the injections than from smallpox vaccinations.

He added he hopes to begin his experiments April 8 or 9.—San Francisco *Chronicle*, March 28.

COMMITTEE ON POSTGRADUATE ACTIVITIES

Fellowships in Health Education—1946

(COPY)

Federal Security Agency
U. S. PUBLIC HEALTH SERVICE
Washington 25, D.C.

Fellowships for one year of graduate study in health education, leading to a master's degree in public health, are being offered to qualified men and women by the U. S. Public Health Service through funds made available by the National Foundation for Infantile Paralysis.

The Fellowships Provide

Training.—A year's study in public health education in an accredited school of public health. This training includes an academic year of eight or nine months and three months of supervised field experience in community health education. The courses include: public health administration, epidemiology, public health and school health education, problems in health education, community organization, and information techniques.

Financial Assistance.—A stipend of $100 a month for the entire period of academic and field training, tuition, and travel expenses for field experience. Travel to and from the university at the beginning and end of training is not included.

Date Effective

Fellowships are effective for the academic year starting in the fall of 1946.

Who Are Eligible to Make Application

Men and women, in sound health, between the ages of 22 and 40, who are citizens of the United States and who meet the entrance requirements of the School of Public Health of their choice. In addition to a bachelor's degree from a recognized college or university, courses in the biological and/or physical sciences, sociology, and education may be required. Training in public speaking, journalism and psychology and work experience in a related field are desirable.

How to Apply for a Fellowship

Application forms may be obtained from the Surgeon General, U. S. Public Health Service, Washington 25, D.C. Completed forms, accompanied by two recent photographs, and official transcript of college credits, and a 500-word statement of why applicant is interested in entering the field of health education, must be in the hands of the Surgeon General by June 1, 1946. Only complete applications will be considered.

Veterans Are Eligible

Veterans with necessary qualifications are encouraged to apply for fellowships. The subsistence allowance for veterans granted under the G.I. Bill of Rights will be supplemented by fellowship funds to bring the stipend to $100 a month.

Miscellaneous Information

Candidates must maintain a scholastic average of "B" to retain fellowship.

Persons accepting fellowships will be expected to work in the field of health education for at least two years after completion of training.

The U. S. Public Health Service and the National Foundation for Infantile Paralysis assume no responsibility for placing fellows in positions.

Schools of Public Health include: Columbia University, Harvard University, Johns Hopkins University, University of California, University of Michigan, University of Minnesota, University of North Carolina, and Yale University. Candidates will be permitted to express their choice of schools, and effort will be made to grant first or second choice insofar as possible.

These fellowships are not available to employees of health departments, as grant-in-aid funds are available for the training of such personnel.

Applications must be in the office of the Surgeon General, U. S. Public Health Service, Washington 25. D.C., not later than June 1, 1946, to be considered.

American College of Surgeons

Medical and Hospital Meeting in Los Angeles

Opening Wednesday morning, April 17, at 8:30 o'clock, and continuing through Wednesday afternoon, April 18, at The Biltmore Hotel, Los Angeles, was held a Sectional Meeting of the American College of Surgeons. Surgeons, members of the medical profession at large, medical students, and hospital representatives from California and Arizona were invited to attend the sessions, which began each morning with the showing of medical motion pictures, followed by separate sessions from 10:00 to 12:00 o'clock for the medical and hospital delegates.

Dr. Hugh T. Jones of Los Angeles, Assistant Clinical Professor of Surgery (Orthopedics), University of Southern California School of Medicine, President, Southern California Chapter of the College and Chairman, Committee on Local Arrangements, presided at the scientific sessions in the Ballroom for the medical profession on the first morning. At this session Dr. Frederick J. Moore, Dr. Harry Blunden, and Dr. Edward R. Evans of Los Angeles, and Dr. Horace J. McCorkle of San Francisco, discussed "General Principles of Antibiosis with Special Reference to Surgery," and Dr. Frank S. Dolley and Dr. Lyman A. Brewer, III, of Los Angeles discussed "Treatment of Chest Injuries (Illustrated by Motion Pictures in Color)."

Surgeons, physicians, and hospital representatives attended the luncheon in the Renaissance Room at which Dr. Clarence G. Toland of Los Angeles, Clinical Professor of Surgery, University of Southern California School of Medicine and First Vice-President and Governor of the College, presided. Dr. Robert M. Zollinger of Columbus, Professor of Clinical Surgery, Ohio State University College of Medicine and Director of Surgery, United States Veterans Administration, discussed "The Care of the Veteran."

The Wednesday afternoon program for the medical profession consisted of panel discussions on two subjects: Pre- and Post-operative Supportive Treatment, participated in by Dr. Clarence J. Berne of Los Angeles, moderator, and Dr. Leon Goldman of San Francisco and Dr. William H. Snyder of Los Angeles, collaborators; and Treatment of Osteomyelitis, with Dr. John C. Wilson of Los Angeles moderator, and Dr. Samuel S. Mathews, Dr. Harold Crowe, and Dr. Vernon P. Thompson, all of Los Angeles, and Col. Gordon K. Smith, M.C., Region 12, Veterans Administration, collaborators. Dr. Harold Lincoln Thompson of Los Angeles presided.

The dinner for surgeons, physicians, and hospital representatives at 6:30 in the Music Room, was followed by a panel discussion and open forum on Graduate Training in Surgery at which Dr. Gilbert J. Thomas of Beverly Hills, Associate Clinical Professor of Surgery (Urology), University of Southern California School of Medicine, Secretary, American Board of Urology and Regent American College of Surgeons presided. He was assisted by Major General Charles R. Reynolds, Chicago, Director, Department of Graduate Training in Surgery, American College of Surgeons; Lt. Col. Hall Seeley, M.C., A.U.S., Rosenberg, Former Surgeon, United States Army Air Forces, Scott Field, Illinois, and Dr. J. Grafton Love of Rochester, Associate Professor of Neurosurgery, Mayo Foundation, University of Minnesota Medical School, and Neurological Surgeon, Mayo Clinic.

The program for hospital representatives on Wednesday included a panel discussion from 10:00 a.m. to noon on developing and maintaining high standards of administration in the postwar hospital, with A. A. Aita of Upland, Administrator, San Antonio Community Hospital and President, California State Hospital Association, as moderator. The subject for the afternoon panel from 2:00 to 5:00 o'clock was developing and maintaining high standards of professional service in the postwar hospital, and the moderator was Ritz E. Heerman of Los Angeles, Administrator, California Hospital.

CALIFORNIA PHYSICIANS' SERVICE†

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* * *

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A regular meeting of the Board of Trustees of C.P.S. was held on Sunday, March 24th, in San Francisco.

Legal counsel reported that the court has not yet rendered a decision in the case of C.P.S. v. Garrison, Insurance Commissioner.

On acquisition in February, Mr. Bowman reported a total enrollment of 13,333 persons—4,011 in the North and 9,322 in the South. Total membership as of February 28 was 191,707 persons. The average percentage of participation among new groups in February was 83.49. In about half of the new groups, management is contributing to the dues.

Dr. Larsen reported a net gain of 207 professional members during the first three weeks in March, bringing the total membership to 6,295. There are now 356 members in Alameda County, 279 in San Diego and 72 in Sacramento. The program of contacting individual doctors is a continuing one, with 4 persons in the North and 4 in the South devoting full time to this work.

Statistical material distributed to the trustees included (1) Operating Statement (2) Statement of Cash Position and (3) Distribution of Medical and Hospital Service Costs during 1945.

An increase in administrative costs during February and March must be expected due to the inauguration of the Veterans' Program, bringing an increase of approximately 25 per cent in the number of documents handled, number of claims, etc.

Colonels Forrest Bell and Herbert Darling, representing the Veterans' Administration, answered questions and spoke briefly of the aims of the Veterans' Administration in regard to the program, emphasizing the fact that the two most important things were to give service to the veterans and to see that the doctors get paid for their services.

Dr. Gilman reported on the Conference of Presidents, and Dr. Dwight Murray reviewed the meeting of the trustees of A.M.A. Mr. Bowman reported on the first meeting of the Commission of Associated Medical Care Plans, a nation-wide organization for the purpose of furthering voluntary state society sponsored medical care plans, and the board voted unanimously that C.P.S. become a member of the A.M.C.P.

Dr. Madeley outlined the recent trip to New Mexico made by himself and Mr. Bowman to assist in the organization of New Mexico Physicians' Service, and Mr. Bowman reported meeting with the House of Delegates of Montana to assist with the Montana Physicians' Service. There is no expense to C.P.S. involved in aiding these other states.

In the problem of payment to lay laboratories, Dr. Goin appointed a committee consisting of Doctors Curtis, Madeley and Doughty to report back at the next meeting.

The revised fee schedule on radiology proposed by the Pacific Coast Roentgen Society was presented, and the new fee schedule as a whole was adopted.

On the Rural Program, Mr. Bowman reported that Grange committees are being formed, and that solicitation will begin next week in the Fresno area. Participation requirement will be 50 per cent of the membership within the particular area. The Farm Bureau has also expressed an interest in this program, and C.P.S., is working with them.

The unit value for May and June was set at $2.00.

The instructions and forms for use in the Veterans' Program, which are being sent to all physicians, were distributed and procedure was outlined.

The next meeting of the board was set for Sunday, May 5th, in Los Angeles. Meetings of the Administrative Members will be held in conjunction with meetings of the House of Delegates, on May 7th and 9th.

Chester L. Cooley, M.D., *Secretary.*

Western Association of Industrial Physicians and Surgeons

The Western Association of Industrial Physicians and Surgeons is scheduling its annual meeting for June 30, 1946, in San Francisco. Morning and afternoon sessions will be held in the auditorium of the Department of Public Health at 101 Grove Street, and there will be a dinner meeting at the Palace Hotel. An excellent program, with prominent Eastern speakers, is being arranged. For additional information, write to Rodney R. Beard, M.D., 2330 Clay Street, San Francisco.

Placement Service for Physicians in Industry

Physicians interested in industrial medical service may learn of opportunities in this field by applying to:

The Council on Industrial Health
American Medical Association
535 North Dearborn Street
Chicago 10, Illinois.

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† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Headquarters, Hotel Biltmore, 5th and Olive Sts. Dates of meetings: Tuesday, May 7-Friday, May 10, 1946.

American Medical Association. The next annual session of the American Medical Association will be held in San Francisco, July 1-5, 1946. (Monday-Friday, inclusive.)

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in California and Western Medicine for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576. Also, August, 1945, California and Western Medicine, pp. 61-62.) On p. 61 (C.M.A.) and p. 62 (A.M.A.)

Medical Broadcasts*

The Los Angeles County Medical Association:

In May KFAC will present broadcasts on Saturdays at 10:15 a.m.; May 4, 11, 18 and 25.

The Saturday broadcasts of KFI are given at 9:45 a.m., under this title, "The Road to Health."

"Doctors at War":

For radio broadcasts of "Doctors at War" by the American Medical Association, see *J.A.M.A.*

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† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week. In California and Western Medicine, some rosters appear in every second or third issue.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Federation Proceedings:* From H. W. Ades on the corpus callosum to P. C. Zamecnik on lecithin and antitoxin, 1,000 plus experimental biologists abstract accumulated work of war years: symposia include human centrifuge experiments, brain metabolism, various physiological systems, synaptic mechanisms, aviation problems, nutrition, exercise, shock, and temperature regulation from physiologists; carbon metabolism, nitrogen metabolism, growth, mineral metabolism, neurospora biochemistry, isotope biochemistry, respiratory and vitamin enzymes from biochemists; diisopropyl fluorophosphate, antimalarials, anesthetics, autonomic drugs, biometrics, toxicity, chemotherapy, and cardiac drugs from pharmacologists; neoplasms, injury and repair, and hematology from pathologists; diets and world nutrition and vitamins from nutritionists, and antibiotics, viruses and immune sera from immunologists. (*Fed. Proc.*, 5:1-256, 1946.) Silly bureaucracy prevented H. J. Curtis discussing activation of tissue elements by slow neutron exposure, even though published in abstract (*Fed. Proc.*, 5:20, 1946). On what evidence did bureaucrats decide DFP (Diisopropyl fluorophosphate) is optimum of series for choline esterase inhibition? If anything could be gathered from the confusions of the meeting, it is that scientific workers are becoming more Fascistic in this country. L. K. Frank suggests that scientists prepare to act as responsible accountable individuals, in asking pertinent question about obedient patriotic citizens (*Science*, 103:350, March 22, 1946).

2. *More New Journals:* Amsterdamsche Boek- en Courant Maatschappij, Amsterdam, Holland, announces *Excerpta Medica*, an abstract journal to appear in 15 sections covering all phases of laboratory and clinical medicine, with A. P. H. A. de Kleyn, M. W. Woerdeman and W. P. C. Zeeman as editors. Grune & Stratton, 381 4th Ave., N. Y. 16, offer bi-monthly *Blood: The Journal of Hematology*, with appropriate introductory articles on chemical components of blood by E. J. Cohn (p. 3), and primary and secondary splenic panhematopenia by C. A. Doan and C. S. Wright (p. 10). W. D. Postell reviews American contributions to the literature of geriatrics (*Geriat* 1:41, 1946). *Occupation Medicine* rolls along: C. P. McCord & Co. apply N. F. Maclagen's thymol turbidity test of liver dysfunction (*Brit. J. Exp. Path.*, 25:234, 1944) to CCl_4 poisoning (*Occup. Med.*, 1:160, 1946).

3. *Reviving Pharmacology:* G. A. Alles pleasantly revives worthy effort with reports on lack of advantage in depressant action of substituted phenobarbitals, and on a-methalkyl ammonium compounds (*Univ. Calif. Publ. Pharmacol.*, 2:173, 183, 1946). J. H. Masserman and K. S. Yum sensibly analyze influence of alcohol in experimental neuroses in cats, revealing factors in addiction (*Psychosom. Med.*, 8:36, 1946). E. R. Movitt offers *Digitalis and Other Cardiotonic Drugs* (*Oxford Med. Publ.*, N. Y., 1946.) N. H. Fairley & Co. report on paludrine (M4888) in malaria (*Med. J. Austral.*, 1:234, Feb., 16, 1946). E. H. Reinhard, C. V. Moore & Co. give full review of radioactive phosphorus as a therapeutic agent (*J. Lab. Clin. Med.*, 31:107, 1946). Note A. Krogh's

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* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

Croonian Lecture on active and passive exchange of inorganic ions through living membranes (*Proc. Roy Soc. B.*, 133:140, 1946).

4. *Otherwise Interesting:* Sir Henry Dale bravely condemns tendency toward scientific secrecy (*Proc. Roy. Soc. B.*, 133:135, 1946). W. D. Harkins bravely discusses the neutron, the compound nucleus and the atomic bomb (*Science* 103:289, March, 8, 1946). A. Huxley pauses in his retreat from reason (*Perrenial Philosopher,* N. Y., 1945) to confuse further the problems of *Science, Liberty and Peace* (Harper, N. Y., 1946, 86 pp., $1). L. Mumford reminisces toughly on *Values for Survival* (Harcourt, N. Y., 1946, 314 pp., $3). D. Masters and K. Way edit *One World or None*, designed to enlighten, maybe frighten (*McGraw Hill, N. Y.*, 1946, $1). Philosophical Library, N. Y. 16, announce J. Dewey's *Problems of Men* to appear April 29, at $5. And the *Burma Surgeon Returns* (G. S. Seagrave, Norton, N. Y., 1946, $3).

5. *Notes:* M. Maizels discusses action of hemolysins on erythrocytes (*Quart. J. Exp. Physiol.*, 33:183, 1946). L. Kreyberg (Oslo), reports on tissue damage due to cold (*Lancet*, 1:338, March 9, 1946). Randolph Field, Texas, releases mimeoed reports from A.A.F. School Aviation Medicine of which J. S. Gray's is worthy, on multiple factor theory of respiratory regulation. In symposium on antibiotics, our M. Fulton & Co. note that penicillin has no action on alcaligenes (*Science*, 103:361, March 22, 1946). Our G. M. Decherd and A. Ruskin discuss mechanism of A-V block (*Brit. Heart J.*, 8:6, 1946).

Atom Work Brings New Age of Medicine.—Atomic research has ushered in a new age for medicine, says Dr. Robert S. Stone, professor of radiology in the University of California Medical School who recently returned from Chicago and Oak Ridge where he was in charge of health aspects of the plutonium project.

"Large quantities of many radioactive elements will soon be available as tracers for metabolic studies, as diagnostic acids for clinical investigations and as therapeutic agents for treatment of diseases," says Dr. Stone, in a recent survey of the science of radiology from the discovery of the x-ray to the era of atomic power.

Dr. Stone points out that while the use of radioactive materials and neutrons, radiations similar in some respects to x-rays, is in its infancy, enough has been done to indicate that they may change medical procedures as much as have x-rays.

Radioactive elements such as phosphorus, strontium, iodine and sodium have already been used with conspicuous success in determining the mechanism of many complex steps in metabolism.

In the future these and many other radio elements, of which radioactive carbon will be especially valuable, will be available in much greater quantity for scientific research.

Radio Transcriptions: "The Public Comes First."—"The Public Comes First," a new series of six radio transcriptions, prepared by the A.M.A. Council on Medical Service and Public Relations in coöperation with the Bureau on Health Education, is ready for distribution. These transcriptions in which Harriet Hester, nationally known radio script writer, interviews members of the Council deal with various phases of the medical care problem, urban and rural health, voluntary prepayment plans and the A.M.A. Constructive Program for Medical Care. These consist of the following fifteen-minute transcriptions:

"What Constitutes Adequate Medical Care," Dr. Roger I. Lee and Dr. Thomas A. McGoldrick.

"What Are Rural Medical Problems?" Dr. James R. McVay and Dr. W. R. Brooksher.

"The Costs of Illness," Dr. Louis H. Bauer.

"Hospital Insurance and How to Make Use of It," Dr. Alfred W. Adson and Mr. John R. Mannix.

"Prepaid Medical Service Plans," Dr. John H. Fitzgibbon and Mr. J. C. Ketchum.

"The Public Comes First," Dr. Herman L. Kretschmer and Dr. E. J. McCormick.

Notices of this service have been sent to various radio stations throughout the country. Proper committees of county medical societies are urged to contact their local radio stations and schedule these broadcasts. Stations are scheduling these on a sustaining (no fee) basis. These "platters" may be obtained free of charge by writing direct to the Bureau of Health Education or the Council office.

Rural Health Conference.—The first annual Rural Health Conference was held Saturday, March 30, at the Palmer House, under the direction of the A.M.A. Committee on Rural Medical Service. This conference was held in conjunction with the American Farm Bureau Federation and the Farm Foundation. Representatives from the Grange, Farmers' Union and other farm groups were invited. This Conference followed immediately a three-day meeting in Chicago of the Midwest leaders of the American Farm Bureau. Two or more representatives have been invited to attend this meeting from each state medical society.

Honor Dr. Francis M. Pottenger For Tuberculosis Control Work.—In recognition of his many years of service in the fight against tuberculosis, Doctor Francis M. Pottenger was named president emeritus of the Los Angeles County Tuberculosis and Health Association at its recent annual meeting. In behalf of the board of directors of the association, Rabbi Edgar F. Magnin presented him with a framed parchment scroll. The message on the scroll follows:

"WHEREAS, in the life of every institution concerned with the welfare of humanity there is always one individual who, because of his clear vision, crusading spirit and tireless efforts, stands as the living symbol of that institution; and

"WHEREAS, the anti-tuberculosis movement in Southern California has the privilege and honor of having such an individual associated with it; and

"WHEREAS, it is the earnest desire of the Los Angeles County Tuberculosis and Health Association to honor this individual;

"*Therefore Be It Resolved,* that the Los Angeles County Tuberculosis and Health Association create the office of President Emeritus with voice and vote on the Board of Directors; and

"*Be It Further Resolved,* that there be elected to this office a man who was the founder of the anti-tuberculosis organization in Southern California from which sprang not only the present Los Angeles County Association but also the California Tuberculosis and Health Association; a man eminent nationally and internationally as a clinician; a man who not only ministers with great skill to individual patients but who, in the face of public fear of, and apathy to tuberculosis, waged and is waging the war against the disease on the broad fields of public health and a man whose wise counsel, warm friendliness and devotion to the cause is a guide and an inspiration to all who fight the forces of illness—Francis Marion Pattenger, M.D."

Life Insurance Medical Research Fund.—Colonel Francis R. Dieuaide, up to recently Chief of the Tropical Disease Treatment Branch of the Surgeon General's Office, has been named Scientific Director of the Life Insurance Medical Research Fund, it was announced today by M. Albert Linton, chairman of the Fund, 60 East 42nd Street, New York 17, New York.

The Life Insurance Medical Research Fund was established last year to make grants to universities and medical schools for research on diseases of the heart and related diseases. The Fund plans to make grants of more than $3,000,000 for this purpose over the next five years. A total of 147 life insurance companies in this country and Canada are supporting the Fund.

Southern California Public Health Association.—Election of Dr. George M. Uhl of Los Angeles as president, as well as other officers to serve for the coming year marked the close of the recent all day Public Health Conference of the Southern California Public Health Association at the Civic Auditorium.

Other officers are: Dr. H. O. Swartout, president-elect; Dr. Norman B. Nelson, first vice-president; Dr. Harrison Eilers, second vice-president; Dr. Ellarene L. MacCoy, secretary-treasurer; Dr. Meridian R. Ball, assistant-secretary treasurer.

Members of the executive committee chosen were C. L. Senn, Dr. C. R. Buss, Ed Beal, Mrs. M. Smiley, Dr. Ruth Wooley and Dr. Ira Church.

American Physicians' Art Association and American Physicians' Literary Guild at American Medical Association Convention.—About one thousand art pieces and several hundred literary creations all done by physicians throughout the country, will be exhibited during the A.M.A. convention, July 1 to 5, in San Francisco, on the mezzanine floor of the Opera House. All visiting physicians are invited to these galleries as well as to attend with their wives, the annual Art-Guild Banquet, to be held at the Hotel Whitcomb, Crystal Room, 6:30 p.m., Tuesday, July 2, 1946, when the trophy winners will be announced.

For further information, communicate with the Secretary, 526 Flood Bldg., San Francisco 2, California, or telephone EXbrook 6017.

William P. Shepard, M.D., Chosen to Be Next President of the National Tuberculosis Association.—Dr. William P. Shepard, San Francisco, was named president-elect of the National Tuberculosis Association by the board of directors meeting in Chicago, March 9.

Dr. Shepard was chosen to succeed Dr. Victor F. Cullen who resigned and who was scheduled to become president at the annual meeting of the N.T.A. in Buffalo in June. Dr. Shepard therefore will be inducted as president at the June meeting and will preside at the 1947 N.T.A. annual meeting, tentatively scheduled for San Francisco.

Dr. Shepard is third vice-president of the Metropolitan Life Insurance Company. He was the 1943-44 president of the California Tuberculosis and Health Association, and has long been identified with tuberculosis work and activities in the American Public Health Association.

National Hospital Day 1946 Cites: "The Hospital—Your Hope For Health."—Adopting as their slogan *The Hospital*—Your Hope for Health, hospitals all over the nation will celebrate National Hospital Day, 1946, on May 12. Having weathered the strain of wartime operation, hospitals now face the most tremendous task in their history—that of supplying adequate care and adequate facilities to a patient load larger than it has ever before been called upon to handle.

During 1945, hospitals experienced an increase in total number of patient days of hospital care proportionate to the 15 per cent increase of 1944 over those supplied in 1943. "This does not mean that more people have been ill," stated Dr. Peter D. Ward, president of the American Hospital Association, "but simply that the public has become more hospital-minded. Also, the benefits of 'Blue Cross' have made hospital care available to more people. As preventive medicine has come of age, the hospital no longer signifies a place for final and drastic measures; rather it is a place for health protection, where minor as well as major ailments may find alleviation.

"This increased interest in and appreciation of hospital care is due largely to the progress of medical science in the control of disease—progress that has given the American people the most effective medical and hospital care ever offered to a group of comparable size—progress that has in the past 150 years almost doubled the average number of years a man may expect to live.

"It is fitting that on May 12, 125 years since the birth of Florence Nightingale, founder of many of our modern hospital practices, we take stock of the challenge facing our hospitals and their response. Voluntary hospitals, representing two-thirds of the value in assets of all general hospitals in the country, have pioneered in construction planning which will constitute a considerable step toward satisfying present demands. The inauguration of hospital surveys, licensing systems, increased availability of prepaid hospital insurance, the trend toward establishment of health centers and medical insurance—all indicate that on this National Hospital Day, hospitals merit the confidence and support of the public."

Research Donation to Honor Memory of Dr. Philip H. Pierson.—Receipt of a gift of $5,000 for medical research has been announced by Dr. H. G. Trimble, chairman of the board of trustees of Alum Rock Sanatorium, San Jose. The sanatorium is a non-profit institution for the treatment of diseases of the chest.

"This gift," according to Doctor B. H. Wardrip, secretary of the board of trustees of the institution, "will establish the Philip H. Pierson Memorial Medical Research Fund as a dedication to his unselfish devotion in the field of medicine, particularly diseases of the chest."

Dr. Pierson, clinical professor of medicine at Stanford University Medical School and consultant at Alum Rock Sanatorium, died January 17, 1946. Dr. Pierson was vice-president of the National Tuberculosis Association and a past president of the California Tuberculosis and Health Association.

Federal Security Agency: Office of Vocational Rehabilitation.—To advance an expanding physical restoration program, the Office of Vocational Rehabilitation, Federal Security Agency, has acquired the services of five new medical officers and contemplates filling additional full-time posts in the fields of ophthalmology, hospital administration, tuberculosis and psychiatric social work, Director Michael J. Shortley recently announced.

American College of Radiology.—The Annual Meeting of the American College of Radiology will be held in the city of San Francisco, at the Palace Hotel, on June 29, 1946, at 2:00 p.m. This is on the Saturday preceding the American Medical Association meeting which opens on July 1, Monday. The American Radium Society will meet at the Palace Hotel on June 30 and July 1, Sunday and Monday.

College headquarters will be at the Palace Hotel. It is suggested that the Palace be designated as the first choice by all Members and Fellows requesting reservations.

The Board of Chancellors will meet at the Palace Hotel on June 28 and the morning of June 29. A luncheon for Councilors is being planned for Saturday, June 29. The annual banquet of the College will be held that evening, at which time the annual Presidential Address will be presented by Dr. Lowell S. Goin.

This will be the first meeting of the College since June, 1944. Pursuant to the Constitution and By-Laws, the following officers will be elected: president, vice-president, and five Chancellors, two for the College and one each for the American Roentgen Ray Society, the Radiological Society of North America, and the American Radium Society. Nominations for these officers will be presented by Dr. Raymond G. Taylor, chairman of the Nominating Committee.

American Pharmaceutical Association Awards 1945 Ebert Prize.—Research on the sclerosing agent, sodium morrhuate, has won the 1945 Ebert Prize for Dr. Paul Jannke, faculty member of the University of Nebraska College of Pharmacy. The award was made by the American Pharmaceutical Association on the recommendation of the Ebert Prize Committee of its Scientific Section.

The investigations, which will be of value in treating varicose veins, were supported in part by a fellowship from the American Pharmaceutical Association. The American Association for the Advancement of Science and the Nebraska Academy of Arts and Science provided grants-in-aid for early phases of the work.

Dr. Jannke's experiments revealed that contrary to general belief, the more nearly saturated fatty acids of cod liver oil are the more satisfactory sclerosing agents and their action was shown to produce a minimum and only brief irritation.

The research confirmed that commercial samples of sodium morrhuate differ greatly in chemical, physical and pharmacologic properties. The presence of a completely soluble precipitate in some sodium morrhuate solutions for parenteral use did not, however, indicate inferior sclerosing properties.

California Administrative Code For Public Health Now Available.—The California Administrative Code, Title 17, Public Health, which includes all the rules and regulations of the State Board of Public Health is now available from the State Bureau of Printing, Documents Division, 11th and O Streets, Sacramento 14. The price is $2.50 plus tax.

Never before have all the rules and regulations governing the activities of the department been printed in one place or even readily available in any form. They are published in loose-leaf form and will be revised at intervals.

"Studies in Human Fertility—Methods for the Control of Conception."—Such is the title of a sound film which is available without charge to medical groups. The running time is 45 minutes. Interest in the film is evidenced by the fact that it has had 1,700 request showings and been viewed by 70,000 doctors, nurses and medical students.

The film portrays a medical classroom lecture in which the professor explains the knowledge and information necessary to qualify in advising individuals on problems involving conception control.

The physiology and anatomy of reproduction is reviewed in animated drawings and microphotography. Where possible, human specimens have been used, particularly in the development of the follicle. Also included, is an actual shot of cell division in the monkey. This part also contains diagrams, charts and graphs depicting the progress throughout the cycle, of the vaginal glycogen curve, the mid vagina pH curve, the urinary estrogen and pregnandiol analysis, vaginal smears and the cyclic changes in the ovary and endometrium. Following this, is a study of human semen and spermatozoa, with up-to-date technical methods of analysis, study of the normal semen and effect of time and temperature and other factors of recent development. . . .

According to the American Pharmaceutical Manufacturers' Association, arrangements can be made to have "Studies in Human Fertility" shown, without charge, to any size audience, providing it is an accredited medical group. Requests should be addressed to the Film Division, Ortho Pharmaceutical Corporation, Linden, N. J.

Competition in the American System of Free Enterprise.—A recent letter from Robert R. Young, Chairman of the Board, The Chesapeake and Ohio Railway, Company, contains statements that should be of interest to all who are interested in the advancement of scientific medicine, and the promotion of the public health. Excerpts from letter follow:

A Message to Moulders of Public Opinion

Competition is the life of trade. It is also the lash of progress. Competition has rightly been styled the keystone of the American system of free enterprise.

Where competition flourishes, products and services inevitably improve. As an example take American automobiles, acknowledged to be the best in the world. They are the fruits of competition.

Where competition languishes, progress falters. . . .

Advisory Health Councils in School Districts—Pennsylvania Plan.—The establishment of an advisory health council in school districts to study the health needs and to assist in organizing a follow-up program was made mandatory in a recent act of the Pennsylvania State Assembly.

Furthermore, the act provides that "Those making medical and dental examinations shall make an annual report to this advisory council and later make a report on the remedial work which has been accomplished during the school year. This advisory council shall be composed of representatives of the medical and dental associations, social organizations, veterans' organizations, parent-teacher associations, service clubs, and other organizations in the area served."

Thus the responsibility for providing corrective service for medical and dental defects is placed squarely on the community.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Doctors Will Campaign for Health Plans

Inauguration of a State-wide drive to encourage every California citizen to enroll in some voluntary health insurance plan was announced yesterday by the California Medical Association, through its president, Dr. Philip K. Gilman.

The campaign will be financed and carried on by the medical profession with the support of the insurance industry and various civic and fraternal organizations, according to the announcement from the C.M.A.

A series of "voluntary health insurance weeks" will be sponsored in each of the counties of the State this year and next.

County Campaign

The first counties in which the drive will be conducted will be Solano and Orange. Next week, the drive will swing to Santa Cruz county.

It is proposed that city and county officials, civic leaders, county medical societies, insurance and fraternal leaders and representatives of the California Physicians' Service, a C.M.A. affiliate, will have a part in the local "health insurance weeks."

Twenty counties are to conduct separate, localized campaigns this year, with similar drives scheduled for the remaining 38 counties in 1947.

Mass Meetings

Public mass meetings and all forms of advertising media will be utilized in the drive to enroll the citizens in some voluntary health plan. The campaign is being directed by the same committee which successfully handled the opposition to the proposals at the 1945 session of the Legislature for enactment of a compulsory health insurance system for California workers.

"This will be a crusade to take the economic shock out of illness or injury," Dr. Gilman said, "and the medical profession is contributing heavily, both of its money and its energy, to encourage every California citizen to enroll in a sound voluntary health insurance plan."

According to the C.M.A., 1,900,000 persons are now enrolled in health and accident insurance plans; 230,000 in hospital plans and 871,000 prepaid medical care plans.—San Francisco *Chronicle,* April 22.

Doctors Can Call V.A. Collect on Veterans' Treatment

California physicians were notified yesterday that they can make collect telephone calls to the nearest office of the Veterans' Administration to determine whether they will be paid for emergency treatments to veterans.

Lieutenant Colonel Forrest G. Bell, deputy surgeon general of the Veterans' Administration, announced the procedure is meant to speed up treatment of veterans. In special cases, treatment may be started and the call for authorization made later, Colonel Bell said.—San Francisco *Chronicle,* April 22.

Freedom from Flu

Wartime Vaccine Is on the Market; New Product Good for Two Years

Princeton, N. J., March 19.—(UP.)—A new vaccine capable of providing immunity from influenza has been developed and now can be bought in any drugstore, Dr. Wendell M. Stanley, member of the Rockefeller Institute for Medical Research, disclosed today.

The centrifuge-type vaccine, unknown in 1918 when an epidemic of influenza killed millions throughout the world, is an outgrowth of the war, Dr. Stanley said.

"We had no means of protection against a major flu outbreak when the war came," Dr. Stanley, a biochemist, said. "An epidemic could have sabotaged our war effort. So we accepted the flu problem."

To produce the vaccine, Dr. Stanley injects small amounts of infectious influenza virus into fertile hen's eggs which had been incubated for ten days..

Two days after the injection the eggs then are opened and the extra-embryonic fluids removed under sterilizing ultra-violet lamps. At the time of removal of fluids the chicken is half-developed.

Before bottling the fluids the solution is passed through various centrifugings, and small portions of formalin and phenylmercuric nitrate are added.

This liquid, Dr. Stanley said, will render a person immune from influenza for from one to two years.

It is being made by several manufacturers for retail sale.—San Francisco *Chronicle,* March 20.

British Doctors Plan to Fight Nationalization

London, March 9.—British doctors are getting up a fighting fund sponsored by the British Medical Association to combat the government's nationalized medical service project.

In announcing this the *British Medical Journal* stated: "Should Parliament prove obdurate and refuse to modify proposals in the bill which the profession might consider to strike at essential freedoms of medicine, doctors of this country might have to decide not to work in the new service." The fighting fund was said to be necessary to "further the cause of the medical profession in any major dispute with the government."

The association, which represents more than 50,000 doctors, has guaranteed $400,000 toward the fund and is urging all doctors to subscribe at least $100.—San Francisco *Chronicle,* March 10.

Los Angeles County Health and Welfare in 1945 Cost $105,251,856

Health and welfare services for Los Angeles County moved into big business circles during 1945 with total expenditures reaching $105,251,856, according to a report just issued by the research department of the Welfare Council of the metropolitan area.

Approximately 380 agencies operating 548 programs spent the $105,251,856 for persons residing in the county. Major agencies disbursing the money include: Family welfare and relief, 52.2 per cent; health, 33.7 per cent; child welfare, 7.7 per cent; group work and leisure time, 5.7 per cent; planning and financing, 0.07 per cent.

Child Care Important

Outstanding contribution of Community Chest and other agencies is in the fields of child care, community health services and recreation. Of the total amount spent by field service in the county, private agencies spent 22.9 per cent for child welfare; 50.9 per cent for health and 50.2 per cent for recreation. These services are chiefly preventive in nature, according to the report.

While public tax funds and private voluntary gifts to Community Chest agencies finance the major part of the community's health and welfare program, clients themselves paid $21,331,765 or 20.3 per cent of the total expenditures. This amount was paid in part pay or nominal fee charges by those clients able to pay, the report pointed out.

Sources Enumerated

Sources of funds were listed as follows: Public funds, $72,853,430; Community Chest contributions, $3,916,164; other contributions, $4,668,952; investments, $629,918; persons paying for services, $21,331,765; other income, $1,851,627.

Total expenditures, less payments from persons receiving service, were divided by the county population of 3,342,247 to obtain a net per capita expenditure as follows: Family welfare and relief, $16.08; child welfare, $1.96; health, $5.32; group work and leisure time, $1.52; planning and financing, $0.23.—Los Angeles *Times,* March 10.

Decline of Penicillin Forecast by Scientist

Atlantic City, N. J., March 14.—(AP.)—Penicillin is losing its punch so rapidly that it was predicted today this wonder drug may become almost completely useless in a few years for a number of the most prevalent diseases.

The trouble is not in penicillin, but in special strains of germs, present in many diseases, which are able to resist penicillin, and which are spreading rapidly while their fellows are being destroyed by the drug.

Common Fault

The prediction was made by Dr. Hans Molitor, of the Merck Institute for Therapeutic Research, in a report to the Federation of American Societies for Experimental Biology. He talked to the Pharmacological Society. The trouble that penicillin faces is not new. It happens in most medical remedies. But in penicillin the increase in the germs that tolerate the drug seems to be very rapid.

In some hospitals the cures of venereal disease by penicillin have dropped from the original almost 100 per cent to about 50 per cent. Similar decreases are going on in other diseases, but not so rapidly.

New Dosages

Molitor said there were four ways in which to retard the loss of penicillin's effectiveness.

One is to give overdoses great enough presumably to kill even the resistant germs. This might be fairly safe with penicillin, since it is not toxic.

The second is to combine several other drugs with penicillin. This is done occasionally now. It is not too satisfactory, however, since the combination causes bad reactions in some patients.

The third way is to discover new antibiotics, as penicillin is called. An example is streptomycin. But streptomycin is subject to losing its effectiveness in precisely the same way as penicillin.

The fourth way is to give chemical compounds that make the germs more sensitive to penicillin.—San Francisco *Examiner,* March 15.

U. C. Scientist Finds New Nose Compound

San Francisco, Mar. 25.—A nose drop compound, potent enough to open up nasal passages in common colds and cases of hay fever, yet without the adverse effects for some people of such stimulating drugs as benzedrine, has been produced by Dr. Gordon A. Alles, of the pharmacology department of the University of California Medical School.

Dr. Alles said that while the new compound is not as potent as benzedrine, it acts over the same length of time and is strong enough to shrink the nasal membranes in ordinary cases. . . .—U.C. *Clip Sheet,* March 26.

Hospital Workers Raised in Ten San Francisco Hospitals

Pay boosts ranging from $12.50 to $45 a month—plus $100,000 in retroactive increases—have been awarded 750 nonprofessional employees of ten San Francisco hospitals by an arbitration board, it was learned today.

The benefits apply to orderlies, kitchen workers and housekeeping and laundry employees in Children's, Franklin, French, Hahnemann, Mary's Help, Mt. Zion, St. Francis, St. Joseph's, St. Luke's and St. Mary's hospitals.

The award, made by an arbitration board composed of Hubert Wykoff, Wendell Phillips and George U. Wood, provides for twelve days' sick leave a year, two week vacations after one year's service, a $10 monthly night shift differential and premium pay for split shift work. —San Francisco *Call-Bulletin*, March 29.

State Institutions Need Physicians, Attendants

Thirty physicians and surgeons and 300 hospital attendants are needed to fill vacant positions in California's 10 state mental institutions.

This was announced today by the state personnel board which will schedule civil service examinations for the jobs in the near future. Applications may be submitted before April 10th.

Physicians and surgeons are paid $300 a month, plus maintenance for self and family, and hospital attendants receive a starting salary of $140 a month.—Sacramento *Bee*, March 28.

Los Angeles Population Up to 1,805,687

Washington, March 29.—(AP.)—Los Angeles gained 20 per cent population between April 1, 1940, and January 28, 1946, the Census Bureau announced today.

Its population went up 301,410 in that period to 1,805,687. Between 1920 and 1930, Los Angeles' population went up 114.7 per cent, then went up another 21.5 per cent between 1930 and 1940.—San Francisco *Examiner*, March 30.

Planners See 6,000,000 in Area by 1960

Forecasts on Basis of Traffic Indicate City of 2,500,000

Predictions that Los Angeles metropolitan area will have populations, respectively, of 2,500,000 and 6,000,000 in 1960 were made on March 21 at a joint luncheon meeting of the Central Business District Association and the Los Angeles Traffic Association at the Biltmore.

The forecasts came in discussions of present traffic conditions and estimated needs, with the city's outlook presented by Ralph T. Dorsey, city traffic engineer, and that of the metropolitan area by City Engineer Lloyd Aldrich. Michael F. Shannon, president of the business association, presided.—Los Angeles *Times*, March 22.

Los Angeles, the Fourth City in America

The city's special census reveals that Los Angeles now has a population of 1,805,687. Since the most recent counting of noses in Detroit showed the automobile capital to have only 1,623,452 persons, our community presumably can point with dignity to its position as the nation's fourth city.

Los Angeles has experienced extraordinary growth in the last five years, largely because of the war. . . —Editorial in Los Angeles *Times*, March 28.

Million Jobless Seen in State by End of Year

Berkeley, March 21.—More than 1,000,000 people may be unemployed in California before the end of this year, even with a high level of national prosperity, because the number of jobs available can't absorb the State's enormous wartime population.

This is the possibility seen in two postwar employment studies released today by the Univerity of California Bureau of Public Administration. Although Dr. Samuel C. May, director of the bureau, projects his figures from the peak of employment year of 1943, and Alfred G. Norris, consulting engineer, takes V-J Day employment figures as a base, both studies reach almost the same conclusions.

"California's problem is not reconversion to prior use, but a development of completely new undertakings," Dr. May says. "Because of this the population growth we have experienced must be treated as a major dislocation of our economic structure, rather than wishfully considering it as a continuing trend."—Los Angeles *Times*, March 22.

San Diego Doctor Gives a "Typewriter" to the Blind

San Diego, April 16.—(AP.)—The equivalent of a Braille pen and pencil for the blind—a vestpocket "typewriter"—was demonstrated here today and the Lions Club of San Diego, underwriting production, announced the first 1,000 would go free to sightless war veterans.

Dr. Alfred Banks, former San Diego city health officer, demonstrated the machine he perfected after being threatened with blindness himself. The device, weighing 18 ounces, has six keys and a space board. It stamps the Braille characters in thin paper tape, similar to that used in stock tickers. The machine's operation is silent.

Dr. Banks disclosed that he had "turned over the patents to the blind of the world, with the Lions Club of San Diego as custodian."

The inventor, who worked on the tiny machine 12½ years, said it could be used for Braille "long or short hand."

No blind person, Dr. Banks has specified, can be charged more than five dollars for the machine, which is being manufactured in quantity by the International Business Machine Corporation for the Lions' Club blind welfare club here.

The club, which estimates the cost of each machine at $15, plans to underwrite the difference. Roberts said that blind persons should get in touch with their local Lions Club for information.

Veterans—Gen. Omar Bradley Making Progress the Hard Way

Less than a year ago, far-flung American armies were sweeping across Europe toward the final victory. Today one of the chief authors of that victory, General Omar N. Bradley, is head of the Government agency that oversees the interests of a vast army of veterans.

When General Bradley was drafted by President Truman to be head of the Veterans' Administration, he could hardly have realized what was ahead of him. The job is so big, it is hard to grasp.

In July of 1945, there were 2,680,000 veterans of World War II. The figure for the end of March of this year was 11,310,000. When the veterans of other wars are included, the grand total is 15,296,000. That is a large chunk of the population. If you include families, with an average of four to a family, you get something close to half of all the people in this country.

Inheriting a warn-out, overworked and hidebound organization, Bradley is beginning to make progress. At least, he's beginning to see the light over the mountain of official documents and papers that, at the beginning of his term of serviture, loomed like one Pike's Peak piled on top of another.

Long Hours of Hard Work

That progress has come out of hard, unremitting toil; out of ceaseless, patient effort 14 or 15 hours a day. With the country in the midst of a growing boom, there have been obstacles that seemed at times insurmountable.

The paper work connected with pension claims, veterans' insurance, and education under the G.I. Bill of Rights, has doubled and tripled from week to week. There was a big backlog when Bradley took over.

To get this moving so that it would be current meant more office space. It meant going into cities that were regional headquarters for the Veterans' Administration to try to find thousands of square feet of office space. It meant trying to hire hundreds of additional clerks in a boom market.

Slowly but surely, the waiting list is being cut down. In February, for example, 660,899 disability or compensation cases growing out of World War II were pending. By the end of March, this has been reduced to 554,917.

Mere figures hardly convey the picture. It snowballs so rapidly. A year ago, there were only a few hundred thousand veterans paying premiums on the insurance they took out during the war. Today the figure is around two million. Two million letters a month, many of them without the necessary information, many of them without a proper address.

One special problem is causing Bradley a lot of worry just now. Months ago, a program of hospital construction was blueprinted. It provided for the building of 75 hospitals in a program that would enable the Veterans' Administration to stay up with its case load through 1950. Congress in due course appropriated the money, specifying a fixed amount for each of the hospitals.

Hospital Building Plan Stymied

Not long ago, the Veterans' Administration called for bids on two of those hospitals. In each instance, letters were sent to about 200 contractors who would presumably be interested in bidding. For the proposed hospital at Grand Junction, Colo., three bids came in. They were nearly 100 per cent over the cost allowed by Congress.

On the other hospital, at Providence, R. I., one bid was received which was about 60 per cent above the cost allowed in the congressional appropriation.

That, of course, reflects the boom. Contractors simply aren't interested in Government construction on a narrow margin of profit. They hope for a killing in a sellers' market.

This makes a new and very tough problem for General Bradley. In effect, it means he cannot build any of the 75 hospitals because Congress has specified the exact amount to be spent on each one. He must therefore go back to Congress to get new legislation, which is a lengthy and sometimes a painful process.

There are other complications. Almost every congressman wants a veterans' hospital in his district. Too often these congressmen are thinking not of the veterans but of payrolls and patronage back home. It has been hard to resist the pressure. It has come from so many different sources.

But there is progress. That is the encouraging thing.—Marquis Childs in San Francisco *News*, April 17.

Foreign Ills Threaten U. S., Dr. Geiger Warns

Health Chief Cites How Air Travel Can Bring Strange Diseases Here

A warning that northern California can expect a rising threat of epidemics similar to the recent smallpox incident was forthcoming yesterday from Dr. J. C. Geiger, city health director, who added the grim observation that northern California "is not always or fully prepared to combat such potential outbreaks."

The threat and inconvenience which smallpox posed for countless thousands of northern Californians—as of April 1, vaccine points totaling 610,000 were used in San Francisco—may be repeated "tomorrow or next week or next month," Doctor Geiger declared, next time by any one of a half dozen diseases, stages of which are endemic or epidemic in far flung corners of the earth.

They would be diseases generally strange to the American scene; scrub typhus, the encephalitis of Japan and others until recently unknown except to specialists in the field of rare oriental or tropical diseases.

What has caused this once fantastic improbability to become a real threat is swift and modern air travel, with San Francisco, destined to become one of the great air crossroads of the world, less than forty-eight hours by air from any point on the globe. . . .—San Francisco *Examiner*, April 17.

MEDICAL JURISPRUDENCE†

Hartley F. Peart, Esq.
San Francisco

Part II

(Continued from page 162 of March issue)

Privileged Communications Between Physician and Patient in California

Information that is Priviledged. The privilege extends to any information acquired in attending the patient which was necessary to enable the physician to prescribe or act for the patient. In *Kramer vs. Policy Holders Life Insurance Association* (1935) 5 Cal. App. (2nd) 380, Mrs. X in making application for an insurance policy on February 2, 1930, in response to questions, stated that she had consulted a doctor within three years for a minor operation of the breast but had fully recovered from such operation and that her present state of health was good. Relying upon the truth of these representations, the policy was issued on February 5, 1930. Mrs X died on August 29, 1931. In an action by Mrs. X's husband to recover on the insurance policy, a doctor who had examined Mrs. X on July 2, 1930, was questioned as to the result of such examination. During the examination, the doctor took the patient's history and made a physical examination. From the patient he learned, among other things, that between the 11th and 24th of December, 1929, less than two months before the acceptance of her application for insurance, she had undergone an operation upon her breast for cancer. The admission of this evidence was objected to on the grounds that it was within the physician-patient privileged communication rule. The lower court sustained the objection whereupon an appeal was taken. The California Appellate Court held that such information was within the physician-patient privileged communication rule because such information was necessary to enable a physician to prescribe or act for the patient.

Autopsies. In this portion of our discussion, we shall not be concerned with the question of authorization or permission to perform an autopsy. Our sole purpose here is to discuss only the disclosure by a physician of facts which he has obtained as a result of an autopsy. The general rule in California is that the privilege is applicable only if the relation of physician and patient exists. Therefore, a physician may testify as to any information which he has acquired while performing an autopsy. In *Harrison vs. Sutter Street Railroad Company* (1897) 116 Cal. 156, a physician had made a medical examination of the deceased after the accident and had performed an autopsy upon the body. The lower court permitted the doctor to give the results of the medical examination but excluded his testimony as to what was disclosed by the autopsy upon the theory that the latter was privileged information and therefore inadmissable. The California Supreme Court held that the evidence should have been admitted saying that a dead man is not a "patient" capable of sustaining the relationship of confidence toward his physician which is the foundation of the rule given in the statute.

Exceptions to the Privileged Communication Rule. It has been stated by several leading authorities that the exceptions to the physician-patient privileged communication rule are so extensive and numerous that they, in effect, operate to cut down the scope and extent of the statutory law. The reason for the large number of exceptions is that the physician-patient privileged communication rule can, if utilized by unscrupulous or dishonest patients, be used for purposes of fraud. Therefore, it becomes important to examine the many exceptions to this general rule enacted by the California Legislature and interpreted by the California Courts. The first exception set forth in Subdivision 4, Section 1881 of the *Code of Civil Procedure* is that in a probate matter where a will or other instrument executed by the patient transferring any real or personal property is contested, then the physician may testify as to the mental condition of the patient and may disclose information acquired by him concerning the deceased which was necessary to enable him to prescribe or act for the deceased.

The second exception set forth in the above cited section is that if the patient is deceased, the executors of his will or the administrator of his estate or the surviving spouse of the deceased, or if there be no surviving spouse, the children of the deceased personally, or if minors, by their guardian, may waive the privilege in any action or proceeding brought to recover damages on account of the death of the patient.

The third exception to the general rule is that where any person brings an action to recover damages for personal injuries, such action shall be deemed to constitute a consent by the person bringing such action, that any physician who has prescribed for or treated said person and whose testimony is material in said action, shall testify.

The fourth exception is that the bringing of an action to recover for the death of a patient by the executor of his will or by the administrator of his estate or by the surviving spouse of the deceased, or if there be no surviving spouse, by the children personally, or if minors, by their guardian, shall constitute a consent by such executor, administrator, surviving spouse, or children or guardian to the testimony of any physician who attended said deceased.

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† Editor's Note.—This department of California and Wester Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

A fifth exception is found in the *California Labor Code* and concerns only cases arising under the Workmen's Compensation Act. Thus in Section 4050 of the California Labor Code, it is set forth that:

> "Whenever the right to compensation under this division exists in favor of an employee, he shall, upon the written request of his employer, submit at reasonable intervals to examination by a practicing physician, provided and paid for by the employer, and shall likewise submit to examination at reasonable intervals by any physician selected by the commission or any member or referee thereof."

The statute then goes on to provide in Section 4055 that:

> "Any physician who makes or is present at any such examination may be required to report or testify as to the results thereof."

In *Winthrop vs. Industrial Accident Commission* (1934) 220 Cal. 114, although the court did not make a decision squarely on the point of physician-patient privileged communication in workmen's compensation cases, it stated that "there is matter in the return to the writ which tends to show that the surgeon's 'refusal' to make a report arose from his *mistaken belief* that the law as to privileged communications applied to him under the circumstances."

(To be continued)

LETTERS†

Concerning Selective Service Statistics:

(COPY)

United States Senate
Committee on Education and Labor
Subcommittee on Health and Education
March 15, 1946

The Editor,
California and Western Medicine,
California Medical Association,
Room 2004, Four Fifty Sutter,
San Francisco, California.

Dear Sir:

Thank you for sending me a reprint of your December, 1945, number. Since it calls sympathetic attention to an attack on President Truman's and our interpretation of the Selective Service rejection data by Dr. Lowell S. Goin, I presume you would not be averse to my comments.

Our data was obtained from the Selective Service System, and our interpretation based partly on the cautious, sensible statement presented by the Chief of its Medical Division, the distinguished medical scientist, Colonel Leonard G. Rowntree, and partly on various independent studies and analyses which we have in our committee files. We stated that a sixth of the rejectees were rejected for defects remediable as far as medical science was concerned; e.g., such defects as hernia and syphilis. The Army has remedied some 16,000 cases of hernia and 166,000 cases of syphilis, evidence that "the type of medical care program" can and does affect the remedying of unremedied defects. For the first time, many of these cases had medical care freely available to them, with no financial barriers to such care. It is true, of course, that a certain amount of compulsion was involved in these cases. Such compulsion does not exist in any civilian medical care program.

We stated that an even larger percentage of defects are preventable. We certainly do not agree with Dr. Goin that a better medical care program cannot prevent (or cure) some cases of blindness, for example. Indeed, I am amazed at Dr. Goin's fatalism concerning the impossibility of a better medical care program preventing or curing many common diseases. It continues to strike me as very curious that a Senate Committee should have to fight with organized medicine to prove that our national medical care needs are serious, and that our health conditions are susceptible of improvement.

Dr. Goin makes a great deal out of the difference in the exact figures in our chart, our text, and the President's message. The differences are not errors on our part. They are due to the obvious difference in the totals as time went on. Our chart was based on June 1, 1944, data. By the time the report was written and published, it was already January, 1945, and we corrected the text to the current figure. President Truman's message appeared in November, 1945, by which time the number of rejectees had risen by almost another half a million. Thus, there is a simple explanation for what is presented as evidence that we are not "intellectually . . . very honest." Only a careless reading of the texts in support of a thesis could reach such an unwarranted characterization. It is not in keeping with the high dignity of the profession.

Sincerely yours,
(Signed) Claude Pepper,
Chairman, Sub-committee on Health Education.

* * *

Note. The above letter was sent to Dr. Lowell S. Goin, who in turn, replied to Senator Claude Pepper.

Concerning Brochure for Marriage License Applicants:

(COPY)

City and County of San Francisco
Department of Public Health

George H. Kress, M.D.
Secretary, California State Medical Association
San Francisco, California

Dear Dr. Kress:

Enclosed please find a copy of a pamphlet, "These Moments," which has been prepared by the Division of Venereal Disease of the City and County of San Francisco Department of Public Health. This pamphlet is to be distributed by the County Clerk to applicants for marriage licenses. In a refined and dignified way it attempts to present information regarding venereal disease to these applicants.

On the last page of the pamphlet you will note that a letter signed by the undersigned has been reproduced. It was thought that the California State Medical Association would be interested in the contents of this letter. The letter, in part, reads as follows:

> "Soon you will want to secure a family doctor who will come to know you as a person as well as a patient and who can give you health guidance and consultation through the years. So that he may keep you well, see your doctor regularly every year for physical examinations in order that any developing illness can be checked before it gains a stronghold. When you anticipate children, seek his counsel at the earliest moment. If you do not know a doctor, the San Francisco County Medical Society, telephone WAlnut 6100, will be glad to recommend one to you."

It was thought that you would be interested in announcing this pamphlet in the next issue of California

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† California and Western Medicine does not hold itself responsible for views expressed in articles or letters when signed by the author.

AND WESTERN MEDICINE as this pamphlet should be of considerable interest to the members of our society.

Very truly yours,
s/J. C. GEIGER, M.D.
Director,
Department of Public Health

101 Grove Street.

Concerning Alameda County Sickness Indemnity Committee:

The Alameda County Sickness Indemnity Committee was formed by a group of doctors in Alameda County for the purpose of preserving private enterprise in medicine. These doctors believe that there should be a free choice of physicians by patients and a free choice of patients by physicians.

They believe that any physician wishing to work for a salary or for a panel of doctors or in any way they please should be allowed to do so. They believe that compulsion in any form stultifies the practice of good medicine.

Likewise, they believe that patients should be allowed a free choice of physician and the type of practice of medicine to which they wish to submit themselves.

Many doctors of Alameda County were bitterly opposed to the procedures of C.P.S. Many other doctors were content with it as it was except they felt it was not on a sound financial basis and did not command respect or support because of the very low fees paid.

In the beginning the physicians of California were content in part with this as a political expedient and as an experiment in which data had to be collected for future purposes.

Prepaid medical care presupposes sound insurance principles and/or charity, and by this time it is time to end charity at the expense of the physician alone.

Furthermore, the Alameda Sickness Indemnity Committee was formed because it was impossible to get the above facts debated in the House of Delegates at the Annual Meetings of the California Medical Association.

At the last Annual Meeting of the California Medical Association there was a gentleman's agreement that if the Alameda County delegation did not bring to vote the issue of indemnity insurance vs. service, the Council of the C.M.A. through its president would appoint a committee to study prepaid medical care in all its phases and make recommendations to the next May, 1946, meeting of the House of Delegates. This was done and the Committee under Dr. Lorin Chandler has followed directions well and faithfully and their report is in the hands of the delegates and the officials of the California Medical Association at this time.

Therefore the purposes of the Alameda County Sickness Indemnity Committee will have been accomplished.

With the benefit of the recommendations of Dr. Chandler's Committee, which are the result of many meetings in the past year, each meeting a full day in length, we are assured that the delegates will inform themselves fully as to all the various phases of indemnity insurance vs. closed panel insurance and service.

If the recommendations of the Chandler Study Committee are agreed upon, no licensed physician in the State of California will be denied remunerations from the California Physicians' Service.

And, no patients will be denied the right to go to their own physician if they so desire. If the patients receiving less than a stipulated income elect to go to physician members of the California Physicians' Service they will be guaranteed that there will be no further charge made to them. If, however, they prefer to go to a doctor who is not a member of the California Physicians' Service they will be assured that their money paid through the California Physicians' Service will reindemnify them to the extent of the fee schedule no matter to whom they go.

We believe the philosophy of payment to patients from indemnity insurance companies is correct but we defend the right of any doctor to work under any system he chooses.

We feel that much has been accomplished and whatever the California Medical Association House of the Delegates decides, after free open debate and the opportunity for study that has been given them, should be final. We further believe that whether physicians wish to join as physician members of California Physicians' Service or not each should give his wholehearted support to the California Physicians' Service as he would to any other prepaid medical care plan which clearly states its benefits and its limitations.

We know that the prepaid medical care service plan is no local issue and we are aware that only through trial and error can a perfect system be established.

The criticism of the Alameda County Sickness Indemnity Committee on the whole was constructive criticism and not an effort to destroy California Physicians' Service. It was an effort to improve C.P.S. for the greatest good of the greatest number of patients and the greatest number of physicians.

The officials of the California Medical Association have wholeheartedly supported the Chandler Committee with help of every sort and no expense was spared to make available to them everything that could be gathered in the way of information. We, the Indemnity Committee, as a body wish to express our sincere appreciation of their efforts.

Many things have been said, but the old saying, "The squeaking wheel gets the grease" is still true. While our words were rough at times it was for the purpose of promoting voluntary prepaid medical care and improving the instrument of the California Medical Association.

EXECUTIVE COMMITTEE

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Concerning Recent New York Law on Dissection:

(COPY)

THE EYE-BANK FOR SIGHT RESTORATION, INC.
210 East 64th Street
New York 21, N. Y.

April 11, 1946.

News Editor
California and Western Medicine
Room 2004, 450 Sutter Street
San Francisco, California

My dear Sir:

I am writing to let you know that the Penal Law of the State of New York has been amended so as to authorize dissection of the dead body of a human being and "whenever and so far as the husband, wife or next of kin of the deceased, being charged by law with the duty of burial, (a) may authorize dissection for the sole purpose of ascertaining the cause of death, or (b) may authorize dissection for any other purpose by written instrument which shall specify the purpose and extent of the dissection so authorized."

For your information the number of the Bill is Senate Nos. 863, 2396, Int. 821.

Sincerely,
s/MRS. HENRY BECKENRIDGE
The Eye-Bank for Sight Restoration, Inc.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIX, No. 5, May, 1921

EXCERPTS FROM EDITORIAL NOTES

A Strong State Society.—Do you think it worth while to have a State Medical Society? Honestly, do you? Have you given any personal thought on your own part to the question of what makes a State Society strong, and why you think this State Society should be developed and strengthened? If the State Society *is* worth something to you, does it meet your ideal now of what it ought to be? Consider for a moment what will best serve to build up your State Society. . . .

Then with regard to the Council. A councilor representing a district certainly should be expected to visit his district in all its subdivisions periodically and be in close touch with its needs, its weaknesses and its possibilities of development. It may not be essential for him to submit a written report to the Council of the "state of the union" in his own district, but at least his district should see that it is represented by a man who really represents and knows it. The duties of the councilor certainly are not comprehended alone in attendance on half a dozen council meetings in the calendar year. . . .

In each county society there is room for improvement as we one and all come to a realization of the important service in our professional and civic life which is rendered by our membership in the County Society. Surely, local medical societies of all sorts would do well to affiliate as branches of the County Society. We do not need such a multiplicity of organizations. We do need every respectable doctor to be a County Society member, and it were well if all his professional activities could find expression in the branches and subdivisions of the County Society. The County Society ought to be in a position to touch civic life at every point and to keep itself in the forefront of civic progress. . . .

The Growing Recognition of Anesthesia.—A notable fact in medical progress, during the past few years, has been the increased interest manifested in anesthesia. To the various societies devoted exclusively to this subject, namely, the American Association of Anesthetists, the Interstate, and the numerous state societies — among which are two in California—have recently been added the Canadian Association of Anesthetists and the National Anesthesia Research Society. . . .

The Physician and Social Agencies.—Of necessity, the attitude of the physician toward social agencies must be most sympathetic. His work is so intimately related to social service and so admirably conserved and multiplied by the social worker that he cannot but be interested in the conduct and development of the social agencies. He should be anxious to coöperate. He should be willing first to learn from experts in the field of social medicine, sociology and social relief, as to what is needed of him in this new and fast advancing department. Having learned that, he must in his turn teach, advise and contribute of his knowledge and ability. He must face the

(Continued in Front Advertising Section, on Page 7)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hopted that such presentation will be of interest to both old and new members. Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committe's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco 8.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.
Secretary-Treasurer

Board Proceedings

A regular meeting of the Board of Medical Examiners was held at the Elks Club in Los Angeles, from March 11th to 14th, 1946.

Written examinations were conducted and hearings were held on petitions for revoked certificates, as well as on disciplinary matters.

The following changes were made in the status of licentiates after a regular hearing:

Bergegrun, Katherine, M.D., charged with violation of Section 2385 of the Business and Professions Code, was on March 12, 1946, found guilty and her California license to practice as a physician and surgeon was revoked.

Burson, William Worth, M.D., charged with violation of Section 2377 of the Business and Professions Code, was on March 13, 1946, found guilty as charged and his California certificate to practice as a physician and surgeon was revoked.

Eby, Marvin R., M.D., charged with violation of Section 2390 of the Business and Professions Code, was on March 12, 1946, found guilty as charged and placed on probation for five years, without narcotic privileges or possession.

Koennecke, Clarence Herbert, M.D., charged with violation of Section 2383 of the Business and Professions Code, was on March 13, 1946, found guilty as charged and placed on probation for a period of five years.

Netherton, Frederick Falton, M.D., charged with violation of Section 2391 of the Business and Professions Code, was on March 13, 1946, found guilty as charged and placed on probation for five years, without narcotic privileges or possession.

White, William Wendall, M.D., charged with Violation of Section 2385 of the Business and Professions Code, was on March 14, 1946, found guilty as charged and his certificate to practice as a physician and surgeon was revoked.

Williams, James B., M.D., charged with violation of Section 2390 of the Business and Professions Code, was on March 14, 1946, found guilty as charged and his certificate to practice as a physician and surgeon was revoked.

An additional written examination has been scheduled to be held at the Native Sons Hall, 414 Mason Street, San Francisco, July 1, 2, and 3, 1946.

Three graduates of the Chicago Medical School, Illinois, appeared before the Board at the recent meeting in support of a petition previously filed. The three officers served with distinction in the Armed Forces during World War II. However, because their school of graduation was not on the list of approved medical schools, and because the Business and Professions Code (Medical Practice Act) has not been modified to authorize the Board to make concession for service in the Armed Forces, the Board, after a complete hearing of their plea, was obliged to deny their request.

(Continued in Back Advertising Section, on Page 38)

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† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising, page 6. News items are submitted by the Secretary of the Board.

congestive heart failure

The de-edematizing action of Searle Aminophyllin decreases the cardiac burden, permitting the heart muscle to function more efficiently.

Searle Aminophyllin produces diuresis whether administered orally or parenterally, and thus has a field of usefulness covering emergencies and chronic congestive cardiac failure.

SEARLE AMINOPHYLLIN

contains at least 80% of anhydrous theophyllin.
G. D. Searle & Co., Chicago 80, Illinois

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 334)

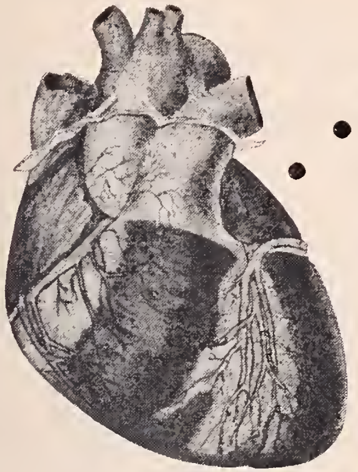
News

"S. F. Doctor Held By State as Faker—A 'doctor' who treated sore feet, sundry other ills, and made dental plates for hundreds of patients during the past twelve months in his Flood Building office was arrested yesterday on charges of practicing medicine without a license. . . . J. W. Williams, chief special agent for the State medical board, said the man, Vincent R. Casey, 38, of 1070 Haight Street, 'admitted never having had any kind of professional training.' Casey was released last night on $500 bail. He is scheduled to appear in court today." (San Francisco, California *Examiner*, March 21, 1946.)

"Chiropractor Given 9 Years to Life Term—Dr. Samuel D. Collins, chiropractor, of 516 S. Commonwealth Ave., today was sentenced to from nine years to life imprisonment for the death of Margie F. Wilson, 22, of 2146 Westview St., who allegedly died after an illegal operation. . . . Collins was sentenced by Superior Court Judge Clement D. Nye on a murder charge and two illegal operation counts. The terms for the three offenses are to run consecutively." (Hollywood, California *Citizen News*, March 21, 1946.)

BAL (British Anti-Lewisite): A New Drug Effective Against Arsenical and Mercurial Poisonings.—BAL (British Anti Lewisite—2, 3 dimercaptopropanol), a war secret until now, discovered in England early in the war, and developed through the joint effort of many agencies in Britain and the United States for use

(Continued on Page 44)



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Yet All These Advantages

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Because it is pure crystalline digitoxin, the dosage of Digitaline Nativelle is measured by weight, hence unvarying potency is provided. Digitaline Nativelle is absorbed in toto, probably directly from the stomach, making for greater tolerability and virtual freedom from nausea and vomiting due to local irritation.

Digitaline Nativelle also provides the outstanding advantage of rapid, complete digitalization from oral administration. The average digitalizing dose is 1.2 mg., given either at one time or in 2 doses of 0.6 mg. each at a 3- to 6-hour interval. Digitalization is complete in 6 to 10 hours.

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THE ORIGINAL DIGITOXIN, IN PURE, CRYSTALLINE FORM

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Digitaline Nativelle is available in ampuls of 0.2 mg. (1 cc.) and 0.4 mg. (2 cc.), in packages of 6 ampuls.

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40 TABLETS
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DIGITALINE NATIVELLE
Alcohol 40%
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The Devereux Schools of Devon, Pennsylvania, and Santa Barbara, California, maintain well-balanced recreational and educational summer camp programs in three coordinated units:

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and the Dietary of Kidney Disease

The fundamental concept, that nutritional requirements must be met in disease as well as in health, holds especially true in renal disease.[1] Because many affections of the kidney involve excretion of blood albumin via the urine, the intake of protein in former years was curtailed in a futile attempt to stem the loss of protein.

Modern nutritional science has emphasized the necessity for maintaining nitrogen balance even in the face of the severe albuminuria characteristic of lipid nephrosis.[2] Not only must the basic nitrogen requirements of the organism be met, but the urinary loss must be compensated for as well.[3] Only when this adjustment of protein intake is made can the plasma albumin be restored to normal levels and the associated edema overcome.

Meat is an excellent source of protein in the management of nephritis and nephrosis, not only because of the high percentage of protein contained, but especially because its protein is of highest biologic quality, applicable for every protein need.

---

[1] *Stare, F. J., and Thorn, G. W.: Protein Nutrition in Problems of Medical Interest, J.A.M.A. 127:1120 (April 28) 1945.*

[2] *Stare, F. J., and Davidson, C. S.: Protein: Its Role in Human Nutrition; Introduction, J.A.M.A. 127:985 (April 14) 1945.*

[3] *Anderson, G. K.: The Importance of Protein in Diet Therapy, J.Am.Dietet.A. 21:436 (July-August) 1945.*

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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For Intravenous and Oral Digitalis Therapy

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Tablets, each contain 0.5 mg. of Lanatoside C
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CHOICE rooms and bungalows. Rates moderate and include routine medical and nursing services, interim physical, X-ray and laboratory examinations, ordinary medicines and pneumothorax. A charge is made for the first complete examination.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

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THE POTTENGER SANATORIUM AND CLINIC · Monrovia, California

BAL (British Anti-Lewisite): A New Drug Effective Against Arsenical and Mercurial Poisonings

(Continued from Page 38)

against one war gas Lewisite, has just been released from restrictions. Properly administered it is very effective against arsenical dermatitis (exfoliative), and arsenical encephalitis resulting from mapharsen treatment of syphilis. It is also valuable against overdose of mapharsen, and possibly of value in cases of blood dyscrasia resulting from arsenotherapy. It is of no value in so-called arsenical jaundice.

BAL has been tried in mercury poisoning and found promising. Animal experiments indicate protection against zinc fumes, and systemic cadmium poisoning. It is effective used locally on the skin or eye against the damage of Lewisite, a war gas, and other visicant arsenicals if used early.

BAL may be used locally or parenterally. For the latter, it comes in 1 cc. ampules given in doses of 1 cc. intramuscularly every (6) hours for (3) three times and then twice daily as the clinical conditions of the patient warrants. It is toxic when given in excessive amounts.

The major medical use for BAL at the present time is for arsenical exfoliative dermatitis where it is quite effective if used early. While not as yet available in regular commercial channels, and still considered to be in the experimental stage, it may be procured from the Los Angeles City Health Department for the treatment of arsenical exfoliative dermatitis.

Now that restrictions are released, further experimental and clinical evalution of this promising drug on other types of poisonings should be forthcoming in the near future. References: R. A. Peters, Nature, Nov. 24, 1945; and L. L. Waters & Chester Stock, Science, Dec. 14, 1945.

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Infants and Children WITH PAPAYA FRUIT

DRIED FRESH TO PRESERVE NATURAL ENZYMES AND PECTINS

Cerol
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Is composed of whole wheat meal, corn meal, wheat germ, malt syrup, dehydrated whole papaya fruit, non-fat dry milk solids, dried brewer's yeast, tri-calcium phosphate, salt, iron pyrophosphate, thiamine, riboflavin and niacin amide.
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DIRECTIONS FOR USE

THE LATEST ADDITION to the famous S. M. A. Infant Foods—CEROL . . . something new in infant feeding—FLAVORED . . . with mellow papaya fruit—FORTIFIED . . . with vitamins and minerals — READY TO SERVE . . . a nutritious, precooked, multigrain cereal—Supplied in 8 oz. packages.

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Patient of intermediate type-of-build (skeleton indrawn)

This lumbosacral support is specifically designed to limit the range of the lumbar spine bending when either the framework or soft tissues of the low back are the seat of injury or disease. Effective support is given the gluteal region, the lumbar spine and the sacro-iliac and lumbo-sacral joints. The adjustment about the pelvic girdle prevents undue pressure of the upper adjustments and yet the presence of the center adjustment gives relief and comfort to the patient. Provision is made for reinforcement with aluminum uprights when indicated.

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Prescribed in many types for the condition illustrated and for Prenatal, Postnatal, Post-operative, Pendulous Abdomen, Visceroptosis, Nephroptosis, Hernia and Orthopedic conditions.

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[1] Virginia M. Monthly 72:240 (June) 1945.

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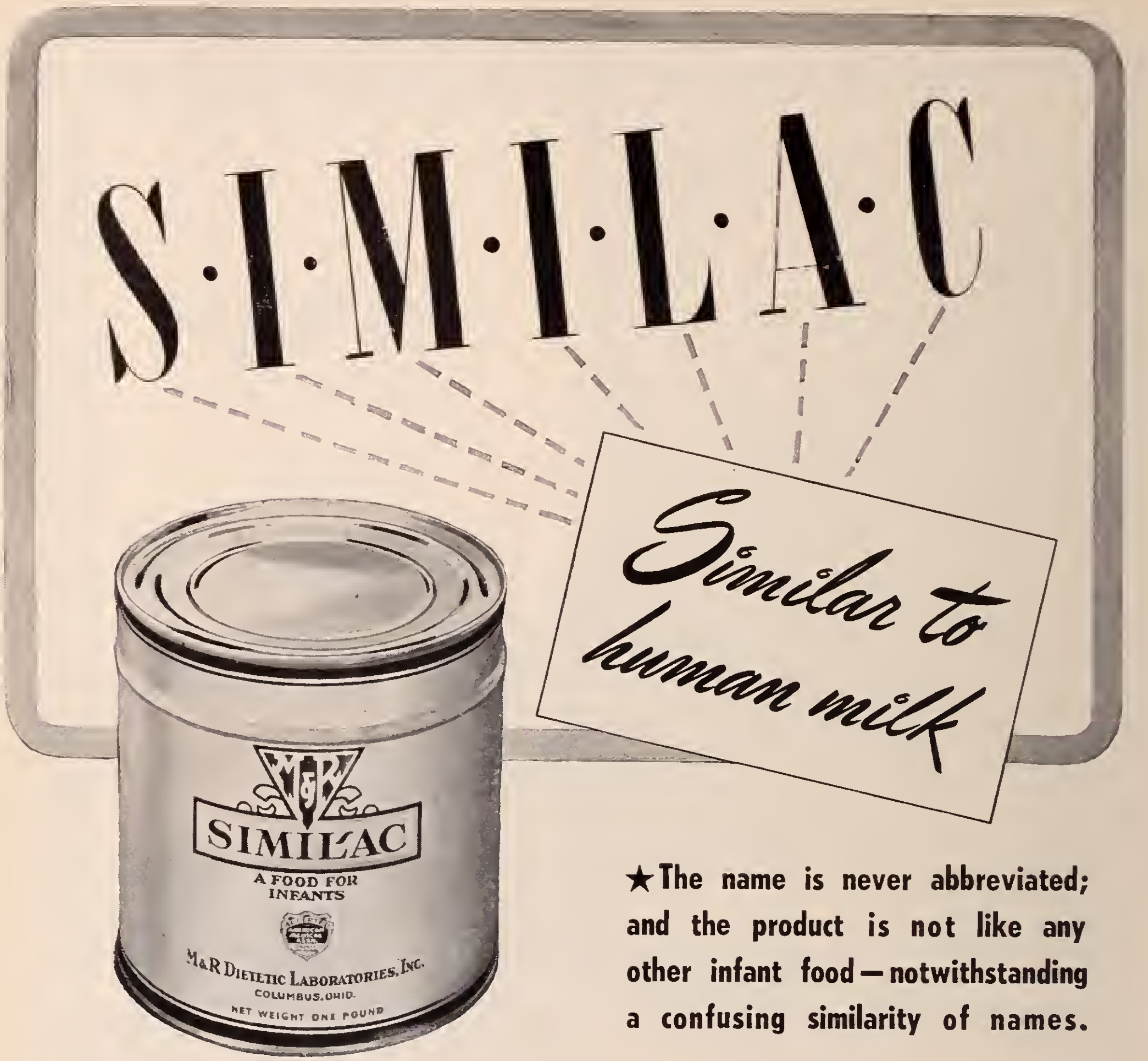

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The fat of Similac has a physical and chemical composition that permits a fat retention comparable to that of breast milk fat (Holt, Tidwell & Kirk, Acta Pediatrica, Vol. XVI, 1933) . . . In Similac the proteins are rendered soluble to a point approximating the soluble proteins in human milk . . . Similac, like breast milk, has a consistently ZERO curd tension . . . The salt balance of Similac is strikingly like that of human milk (C. W. Martin, M. D., New York State Journal of Medicine, Sept. 1, 1932). *No other substitute resembles breast milk in all of these respects.*

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A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil and fish liver oil concentrate.

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U.C.L.A. Establishes a Health Center

Departments to Be Coördinated With State-wide Program

Establishment of a Department of Public Health, to be headed by Dr. Norman Nelson, medical director of the Los Angeles City Health Department, on the Los Angeles campus of the University of California was announced by Clarence A. Dykstra, provost of the university.

Under the new program the university's department of public health will be coördinated with the new $7,000,000 medical school to be located here and the Los Angeles City Health Department will become part of a State-wide public health program directed by the University of California, with headquarters on the Berkeley campus.

Work Begins in March

The new public health department on the local campus began instruction at the opening of the spring semester March 4. It was set up by Dr. Nelson and will instruct not only undergraduates and graduate students, but licensed physicians who want to engage in public health work.

Dr. Nelson will continue as medical consultant for the city, but his present city post will be filled by a new medical director, it was said.

"It is the aim of the State university to build a public health program which will be one of the finest in the country, comparable to the present leaders in the field, Harvard, Yale, Johns Hopkins and Michigan," explained Dr. Dykstra in making the announcement.

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When you come to think of it, it's surprising how much control means. In various forms it adds enjoyment to sports—security to daily routine—satisfaction to work of skill.

And as *quality control* it assures safety in medicines. This is particularly well demonstrated in the development and production of U.D. pharmaceuticals. For throughout modern U.D. laboratories and plants a carefully conceived and remarkably efficient system of tests and checks results in products with an enviable reputation for consistent excellence.

Credit for maintenance of these high standards rests with a body of doctors, chemists and pharmacists, known as the Formula Control Committee. As the ultimate precaution, this group personally checks every finished product.

Such professional attention insures that your prescriptions are filled with finest ingredients when you specify U.D. pharmaceuticals. Your neighborhood Rexall Drug Store offers this service — together with complete facilities for meeting your patients' needs reliably and economically.

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UNITED-REXALL DRUG COMPANY AND YOUR REXALL DRUGGIST • *Your Partners in Health Service*

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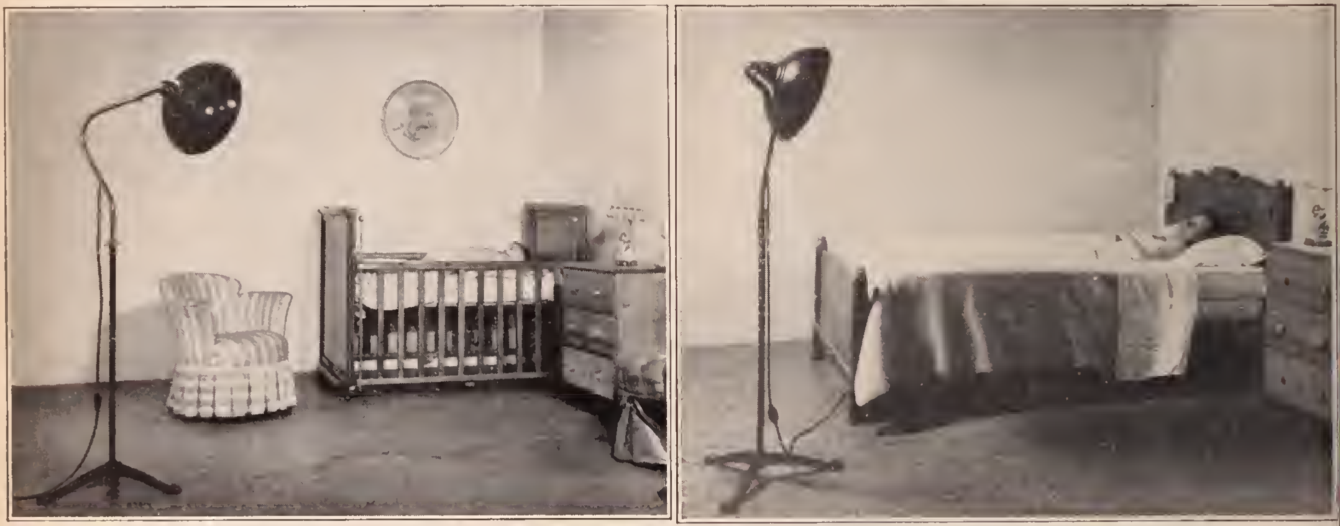
It's an Economical, all night, Dark burning, Portable Desert Air Maker. Offered as an aid for relieving—COLDS and COUGHS—And for drying up

• SINUS • HAY FEVER • BRONCHITIS • ASTHMA

And other respiratory ailments, by providing a zone of all night warm, dry air in your patient's bedroom.

When a change of climate is indicated, you can keep your patient at home.

No leaving the family and business and moving to a warm, dry climate McCall's Desert-Air Lamp brings DESERT AIR to the bedroom.



Your patient will breathe easier and sleep sounder, in this zone of Desert-Air over their bed all night

RENTALS . . . . . . $10.00 per month	
SALE PRICE . . $37.50 3 year guarantee	

First month's rental may be applied on purchase price

Your prescriptions for lamps may now be filled at Drugstores, and most surgical houses. Or if more convenient write or phone our office in Los Angeles—GR 7200

Costs 11 cents to use 10 hours in most places.

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. . . in judging the irritant properties of cigarette smoke . . . to base your evaluation on scientific research. In judging *research, you must consider its source*.*

PHILIP MORRIS claims of superiority are based *not* on anonymous studies, but on research conducted only by competent and reliable authorities, research reported in leading journals in the medical field.

Clinical as well as laboratory tests have shown PHILIP MORRIS to be definitely and measurably less irritating to the sensitive tissues of the nose and throat. May we send you reprints of the studies?

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119 FIFTH AVENUE, N. Y.

**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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THE RELAXATION VALUE OF BEER

...is interestingly discussed by Dr. Peter J. Steincrohn in his latest book, "Forget Your Age," which was reviewed in the September 1945 issue of *Science Digest.*

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high I.Q. (*It Quenches!*)

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Policies in the Care of Children Suffering from Poliomyelitis

Responsibilities for the care of children suffering from poliomyelitis have been defined by an agreement between the National Foundation for Infantile Paralysis and the State Department of Public Health. Procedures recommended are in line with the state department's responsibility for the maintenance of high standards for the care of all crippled children and the National foundation's policy of coöperation with public officials in effecting the best possible results in the care of paralysis patients.

The official state agency providing care for children afflicted with infantile paralysis is the Crippled Children Services of the State Department of Public Health. It has the basic organization for making such provisions, and it is believed that its services should be utilized by the chapters inasmuch as standards of medical care and hospital care of the highest level have been established; a system of follow-up developed through local clinics, health departments, and welfare departments, and its professional staff has had special training and experience.

The chapters of the national foundation have been established to assure the best available medical care to all infantile paralysis patients, and to that end chapter funds are used to provide aid when needed by the patient for hospitalization, medical and nursing service, orthopedic appliances, and transportation to and from hospitals and clinics. In coöperation with the local medical and health authorities, the chapters are a force in the community for the improvement of facilities for the care of such patients. By financing training through scholarships, the chapters raise standards and increase the number of persons who can administer recommended treatment. They also maintain an educational service

(Continued on Page 58)

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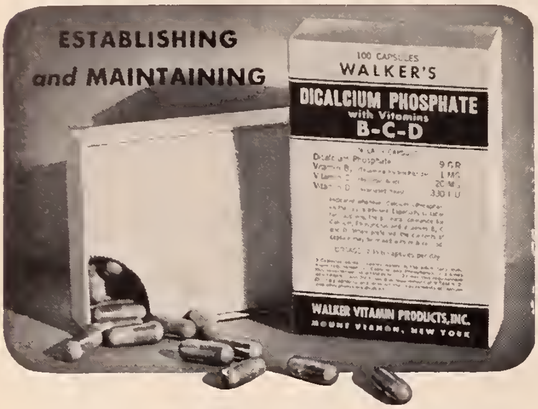
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Policies in the Care of Children Suffering From Poliomyelitis

(Continued from Page 54)

program to keep the public informed on infantile paralysis.

With the foregoing policies and responsibilities as a basis, the following recommendations are made to the California chapters of the National Foundation for Infantile Paralysis:

1. That each chapter become acquainted with the local Crippled Children Services program.
2. That each child under 21 found to have infantile paralysis be reported to the Crippled Children Services.
3. That, where possible, the facilities made available by Crippled Children Services be used to provide the treatment of children under 21 with acute or early infantile paralysis and that the chapter finance the service rendered by those facilities.
4. That old cases of infantile paralysis in persons under 21 should be referred by the chapter to the crippled children's clinics held in the community, that findings and recommendations made there be a basis for future planning, and that costs be paid by the chapters as for acute cases.
5. That children crippled by causes other than infantile paralysis be referred to the Crippled Children Services.
6. That each chapter should pay for medical care where need is indicated for all infantile paralysis patients irrespective of age. Inasmuch as Crippled Children Services can be of no assistance in providing care for those over 21 years, other arrangements for providing care to them will have to be made.

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Parents' Fears and Community Lags Are Holding Back Needed Psychiatric Care for Children, Says Children's Bureau

One child out of 20, at the present rate of commitment, may be expected to spend some period of his life in a mental hospital, and in addition, large numbers of others are doomed to go through life as maladjusted personalities. Yet much of this individual tragedy and social loss could be avoided if "what we know today about mental hygiene were to be applied in time, that is, while these children are still young."

This statement was made on February 17 by Dr. Kent A. Zimmerman, head of the recently established mental health unit of the Children's Bureau, United States Department of Labor. He urged that the needs of this large group of children be brought forward in all Federal, state and community planning for the health and welfare of young people, and called attention to recommendations to that effect, being put forward by the National Commission on Children and Youth, a group of outstanding men and women in the child health and welfare field.

Mental hygiene services for children, Dr. Zimmerman said, should be an essential part of community public health and welfare services, yet full time clinical service for child guidance is provided in only 27 of the largest cities in the United States. One-fourth of the cities of more than 100,000 have no psychiatric clinics for either children or adults, and the same is true in two-thirds of the cities of from 50,000 to 100,000 population. In the small towns and rural areas, where most children live, such a service is almost unknown.

Dr. Zimmerman spoke of the need for specially trained personnel in child psychiatry and related fields and urged that "inducements be offered in the way of scholarships

(Continued on Page 68)

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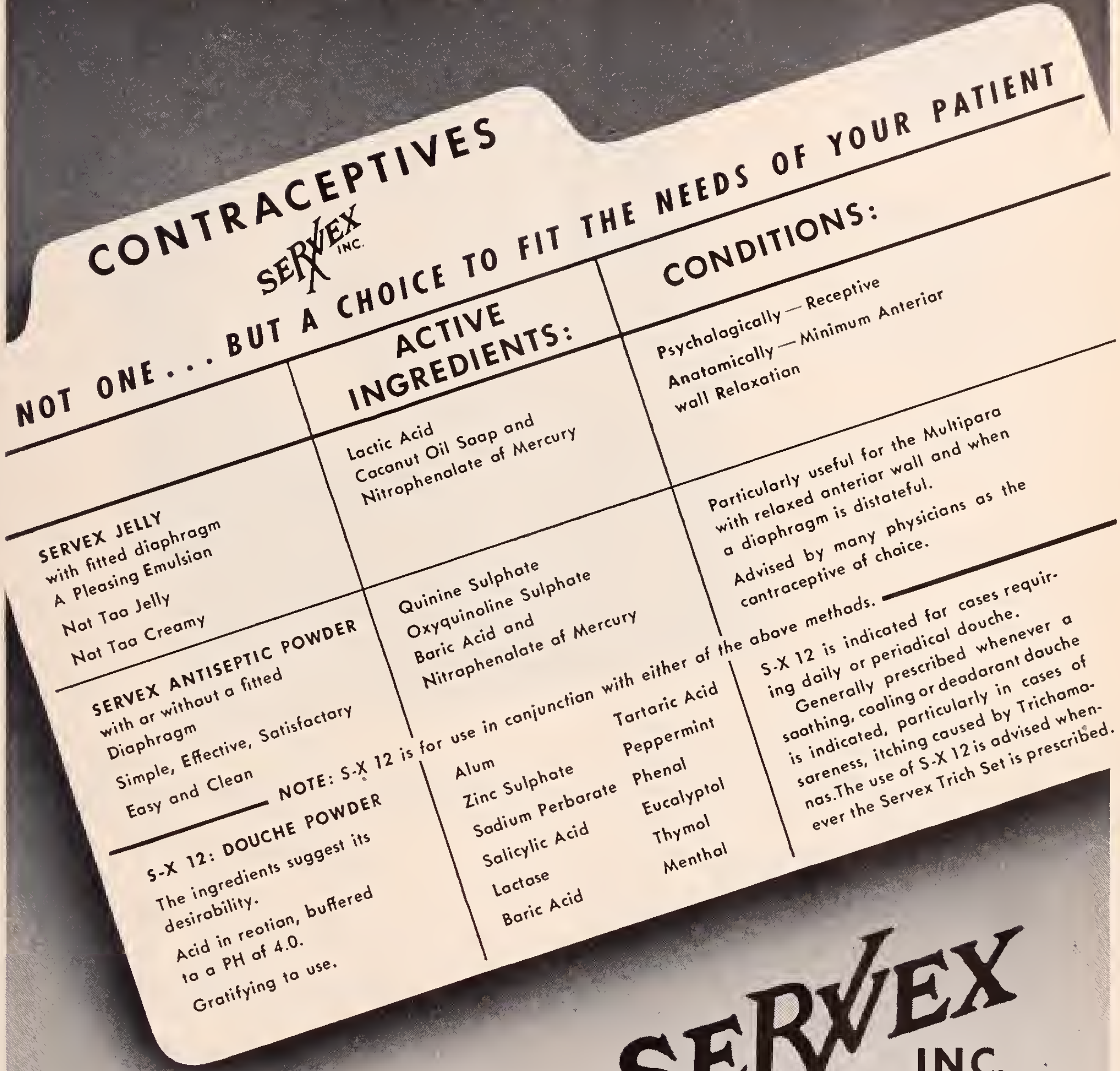

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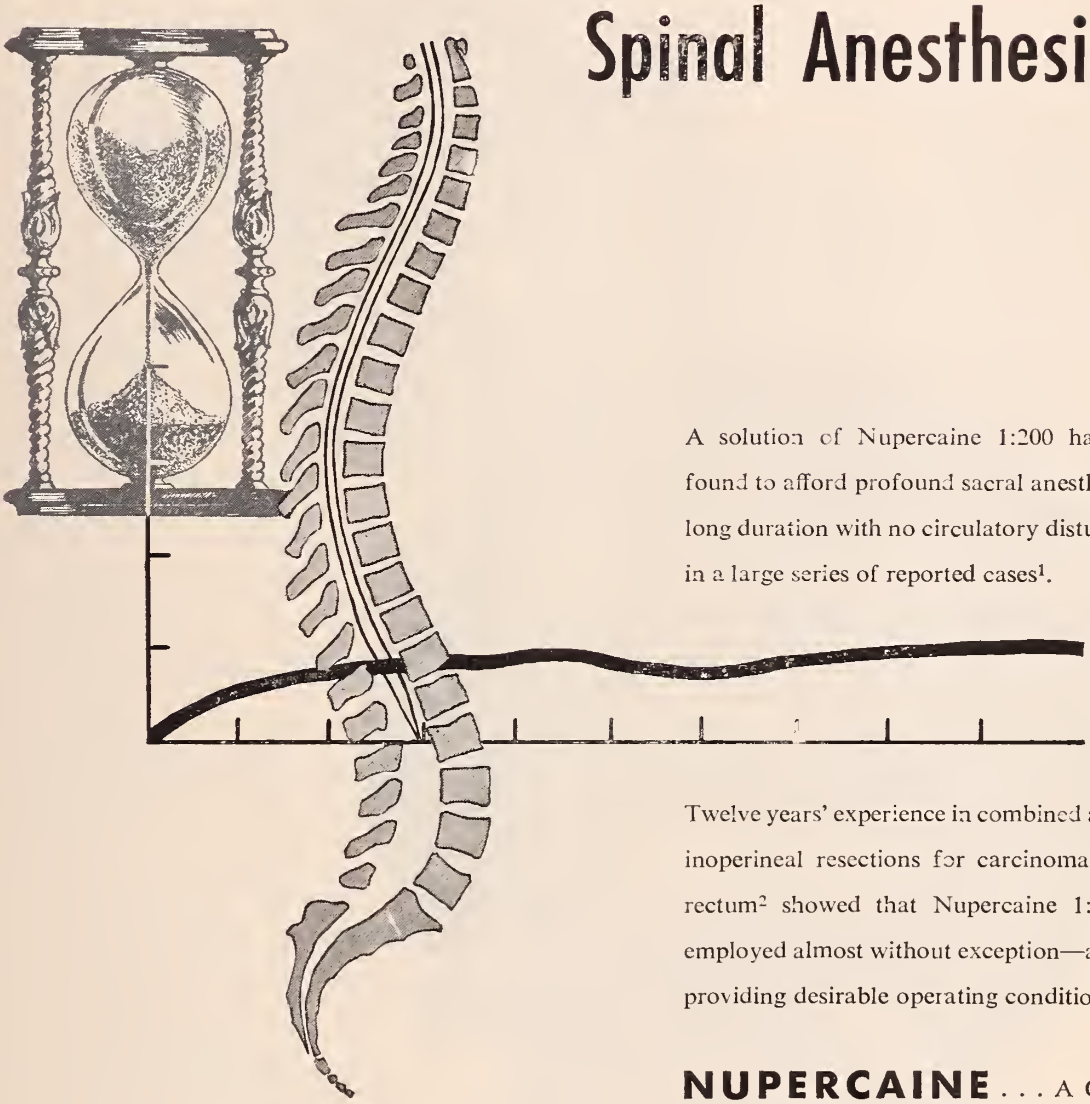

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[1] Clement, F. W. & Elder, C. K.: Anesth. 4:516, 1943

[2] Coller, F. A. & Ransom, H. K.: Surg. Gynec. & Obst., 78:304, 1944

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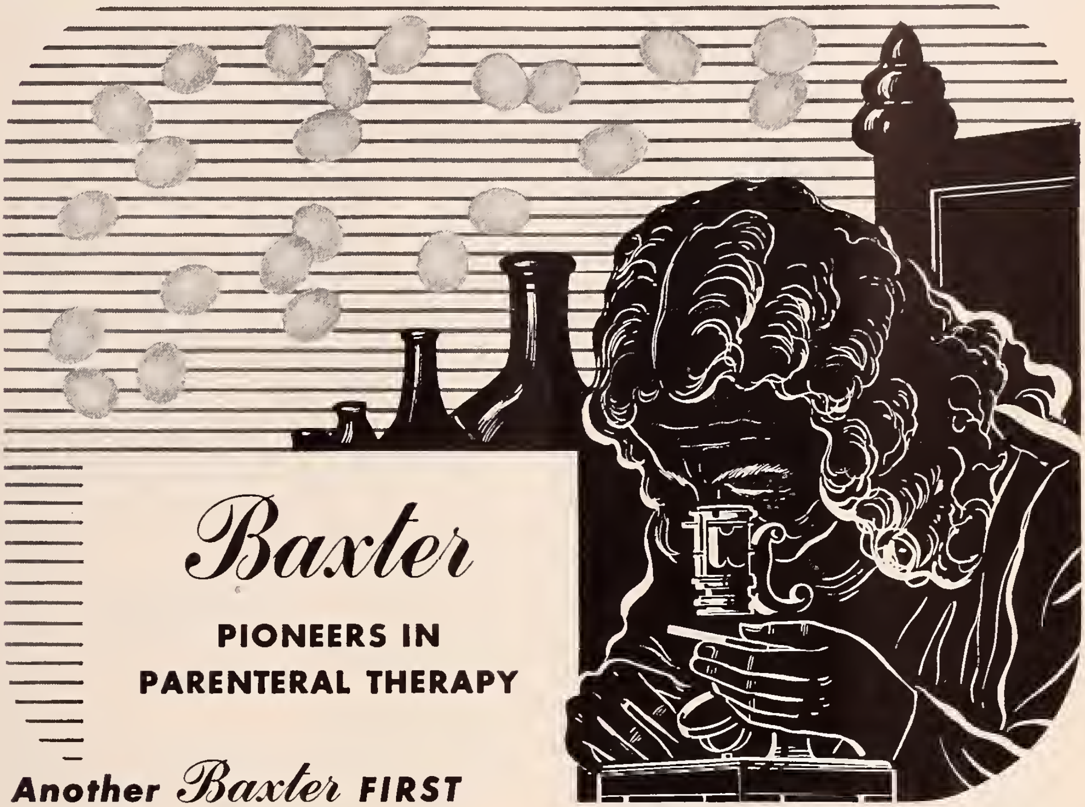

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Parents' Fears and Community Lags Are Holding Back Needed Psychiatric Care for Children, Says Children's Bureau

(Continued from Page 62)

and training opportunities in order to attract men and women into this comparatively new field." The lack of specialists and places where they can be trained, he points out, are already holding back the extension of child guidance work in this country.

The National Commission on Children and Youth is recommending that Federal funds be made available for training in this, as in other health and welfare fields, as a step toward making mental health services available everywhere.

The Children's Bureau, Dr. Zimmerman explained, is helping state health and welfare agencies plan their mental hygiene services for children. To be effective, these services must grow and develop relatively slowly as part of a general program of care for children. To make these services most useful to the community, civic and professional groups, such as teachers, social workers, nurses, parents, doctors, parent-teacher associations, and others, should be identified in some way with the effort so they can learn at first hand the incalculable benefits that good mental health services can give to the community and its children.

They only have lived long who have lived virtuously.
—Sheridan, *Pizarro.* Act iv, sc. 1.

Poor men want meat for their stomachs, rich men stomachs for their meat.
—Anthony Copley, *Wits, Fits, etc.,* p. 105.

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1. Clinic Reports: Planned Parenthood Services in the United States. Human Fertility 10: 25 (Mar.) 1945.
2. Dickinson, R.L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
3. Warner, M.P.: J.A.M.A. 115: 279 (July 27) 1940.

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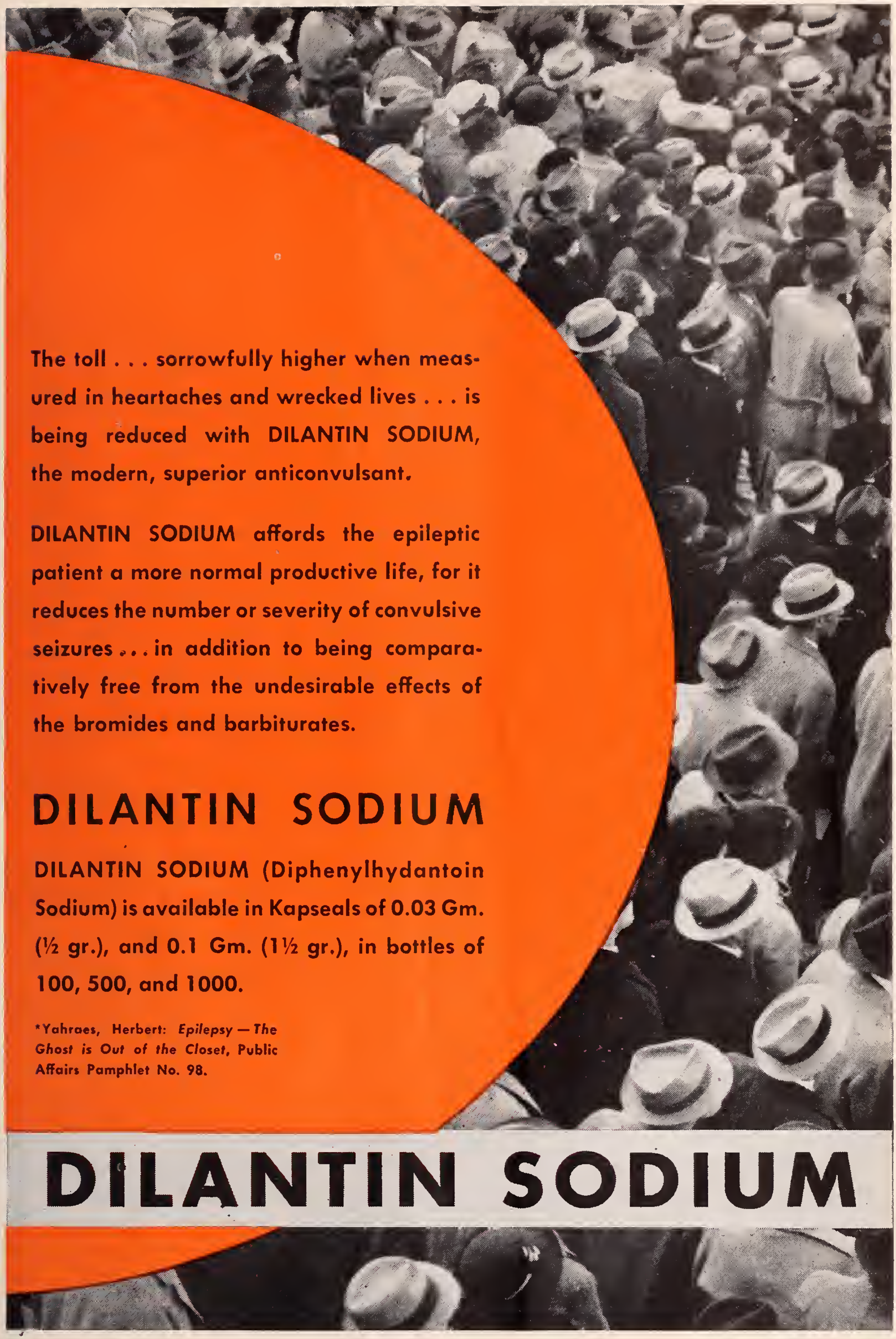

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BOOK REVIEWS

BOOKS RECEIVED

A Blind Hog's Acorns: Vignettes of the Maladies of Workers. By Carey P. McCord, M.D., with illustrations by Strobel. Cloth. Price, $2.75. Pp. 311. Chicago, New York: Cloud, Inc., 1945.

The Biology of Schizophrenia. By R. G. Hoskins, Ph.D., M.D., Director of Research, Memorial Foundation for Neuro-Endocrine Research, Harvard Medical School and Worcester State Hospital. Cloth. Price, $2.75. Pp. 191. New York: W. W. Norton & Company, Inc., 1946.

Electrocardiograph Including an Atlas of Electrocardiograms. By Louis N. Katz, A.B., M.A., M.D., F.A.C.P., Director of Cardiovascular Research, Michael Reese Hospital, Chicago, Illinois; Professorial Lecturer in Physiology, University of Chicago, Illinois. Cloth. Price, $12.00. Pp. 883, illustrated with 525 engravings, including over 1,000 electrocardiograms. Second edition, enlarged and thoroughly revised. Philadelphia: Lea & Febiger, 1946.

Exercises in Electrocardiographic Interpretation. By Louis N. Katz, A.B., M.A., M.D., F.A.C.P., Director of Cardiovascular Research, Michael Reese Hospital, Chicago, Illinois; Professorial Lecturer in Physiology, University of Chicago, Chicago, Illinois. Cloth. Price, $6.00. Pp. 288, illustrated with 141 engravings containing 166 electrocardiograms. Second edition, thoroughly revised. Philadelphia: Lea and Febiger, 1946.

New Drugs. By Arthur D. Herrick, author of "Drug Products: Labeling, Packaging, Regulation" and "Food Regulation and Compliance" (with foreword by Austin E.

(Continued on Page 12)

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[1] *Freed, S. C., and Greenhill, J. P. (1941), J. Clin. Endocrinol., 1:983, December.*

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**These constituents are members of the natural B Complex. Their need in human nutrition has not been established.*

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BOOKS RECEIVED

(Continued from Page 7)

Smith, M.D., Secretary, Council on Pharmacy and Chemistry of the American Medical Association). Cloth. Price, $4.00. Pp. 303. Revere Publishing Company, New York, 1946.

Synopsis of Physiology. By Rolland J. Main, Ph.D., Professor of Physiology, Medical College of Virginia, Richmond. Cloth. Pp. 341, illustrated. St. Louis: The C. V. Mosby Company, 1946.

Ambulatory Proctology. By Alfred J. Cantor, M.D., Associate Proctologist, Kew Gardens General Hospital, Long Island, New York; formerly Assistant Attending Gastroenterologist, Queens General Hospital, and Assistant Adjunct Proctologist, Hospital for Joint Diseases, New York (with a foreword by Beaumont S. Cornell, M.D., Editor, *American Journal of Digestive Diseases*). Cloth. Price, $8.00. Pp. 524, illustrated. New York and London: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1946.

Skin Diseases in Children. Second edition revised and enlarged. By George M. MacKee, M.D., Professor of Clinical Dermatology and Syphilology, New York Postgraduate Medical School, Columbia University, New York, and Anthony C. Cipollaro, M.D., Associate in Dermatology and Syphilology, New York Postgraduate Medical School, Columbia University, New York. (With contributed chapters.) Cloth. Price, $7.50. Pp. 460, with 116 illustrations. New York and London: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1946.

Suggestion and Hypnosis Made Practical: How to Get What You Want. By Samuel Kahn, M.D., Ph.D., author of "Psychological and Neurological Definitions," "Mentality and Homosexuality," "How to Learn and Advance," etc.; formerly Clinical Professor of Neurology and Psychiatry at Georgetown and George Washington Universities, Chief Psychiatrist to the U. S. Army Induction Board for the States of New Jersey and Delaware and faculty member of New York and Long Island Universities. Cloth. Price, $3.00. Pp. 200. Boston: Meador Publishing Company, 1946.

(Continued in Back Advertising Section, Page 44)

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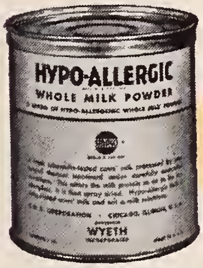
Use one of these Special Infant Foods

Altered Protein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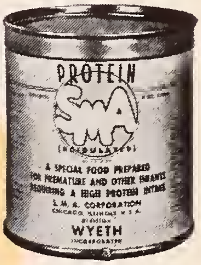
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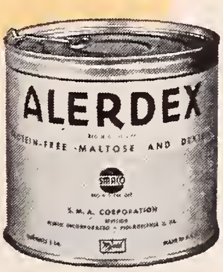
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Ina Gourley, M.D., Oakland

BOOK REVIEWS

Clinical Roentgenology of the Heart. Annals of Roentgenology, Volume XVIII. By John B. Schwedel, M.D., Associate Attending Physician, Medical Division, Adjunct Attending Physician, Dept. of Roentgenology, Montefiore Hospital, New York; Attending Electrocardiographer and Associate Visiting Physician in Medicine, Gouverneur Hospital, New York; Lieutenant Commander, M.C. (V) S., U.S.N.R. Cloth. Price, $5.00. Pp. 436, with 749 illustrations on 232 figures. New York: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1945.

This volume is based on an analysis of over 30,000 fluoroscopic and roentgenographic examinations, including a large number of normal hearts. More than 4,000 of these cases were autopsied and the findings correlated with the clinical and roentgenologic facts.

The author states that the development of roentgenology as it applies, not only to the heart, but to the entire field of medicine, is one of the brilliant achievements of our age.

Roentgenologic techniques are now firmly established in cardiology, but their clinical possibilities in this field have not been fully exploited, due to the fact that clinicians in general have not been overly impressed with the information offered by roentgenologists, because the methods employed only confirm the presence or absence of total cardiac enlargements. It is the purpose of this present volume to focus attention upon roentgenologic methods as applied to diseases of the heart and great vessels, to clarify or develop basic terminology; to assemble various pertinent data on the subject, and to correlate these both clinically and pathologically with other accepted methods for the total clinical approach to cardiovascular disease. Its purpose is selective, not exhaustive; clinical rather than technical and derivitative rather than primary.

Whenever possible, clinical symptoms and signs have been correlated with alterations in the heart as a whole,

(Continued on Page 18)

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. . . when refrigeration is not available, each feeding may be prepared separately. The doctor can always advise the mother to prepare individual LACTOGEN feedings whenever the baby is ready for his bottle. Preparing each LACTOGEN feeding just before feeding time safeguards the baby against the danger of nutritional upsets caused by bacteriological changes in the formula.

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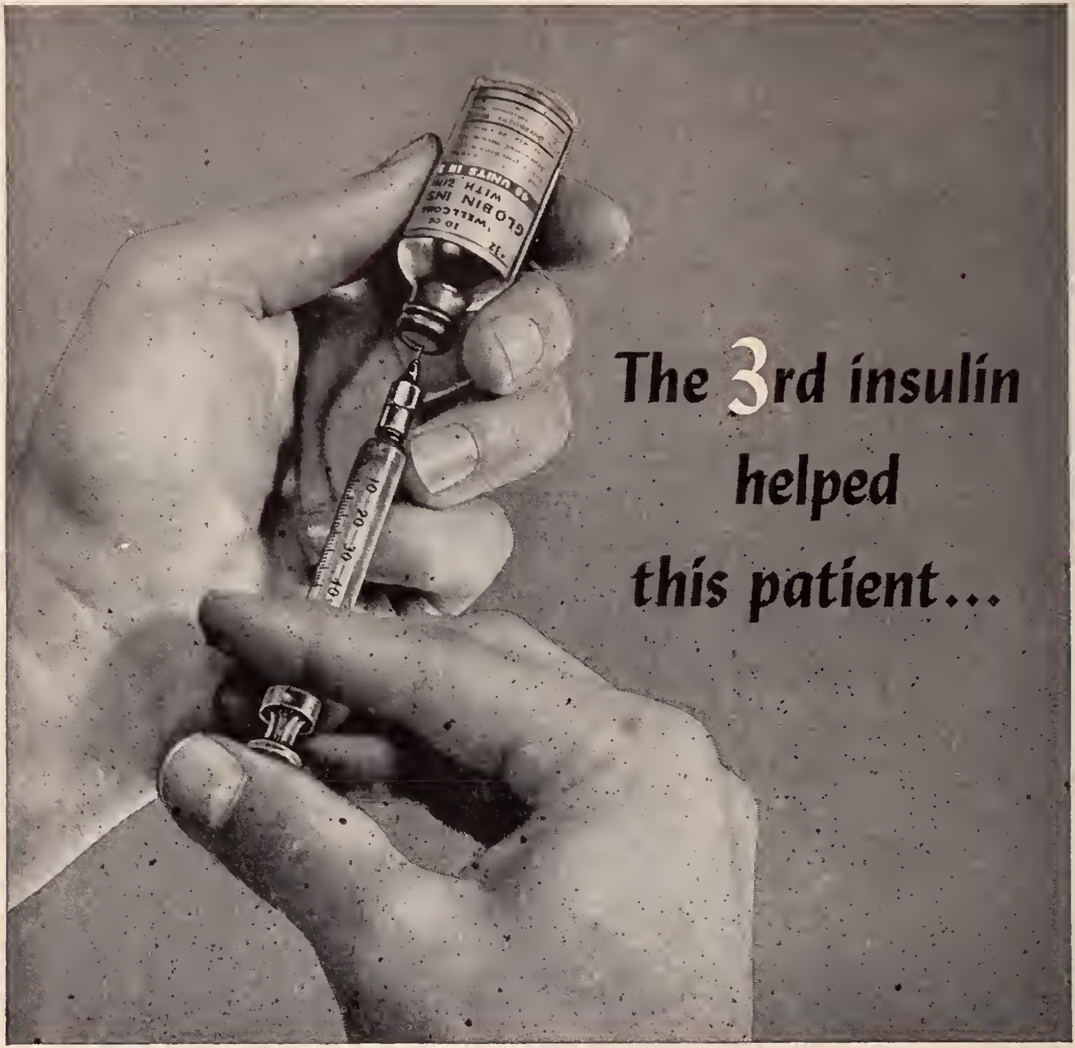

TODAY, the physician treating diabetics, has the choice of three types of insulin. One insulin is rapid-acting but short-lived. Another is slow-acting but prolonged. Between them is the new 'Wellcome' Globin Insulin with Zinc, moderately prompt in starting, yet capable of sustained effect *for sixteen or more hours.* Such intermediate action is sufficient to cover the periods of maximum carbohydrate intake, and diminished enough by nighttime to minimize the likelihood of nocturnal reactions. Physicians do well to consider all *three* insulins when treating their diabetic patients.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

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Available in vials of 10 cc., 80 units in 1 cc., and vials of 10 cc., 40 units in 1 cc. Literature on request. *'Wellcome' Trademark Registered.*

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Globin Insulin
WITH ZINC

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*Based upon (1) the Report of the Council on Foods and Nutrition, J.A.M.A. 126:100, 1944, J.A.M.A. 123:902, 1943 and (2) the label statements of composition of better-known pre-cooked cereals.

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Inglewood: Stoner's Prescription Pharmacy
Long Beach: Thackray's Prescription Pharmacy
Los Angeles: All Horton & Converse Prescription Pharmacies
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Merced: Maze Drug Store
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BOOK REVIEWS

(Continued from Page 14)

but more particularly with changes in the individual cardiac chambers as well as with roentgenologically demonstrable changes in adjacent structures.

The method of presentation employed in this book is the outgrowth of eleven years' experience in teaching postgraduate students interested in heart disease.

The Care of the Aged (Geriatrics). By Malford W. Thewlis, M.D., Attending Specialist, General Medicine, United States Public Health Hospitals, New York City; Attending Physician, South County Hospital, Wakefield, R. I.; Director, Thewlis Clinic; Special Consultant, Rhode Island Department of Public Health. Fifth edition, thoroughly revised. Cloth. Pp. 500, with 65 illustrations. St. Louis: The C. V. Mosby Company 1946.

The text of this (5th) edition contains many alterations. Added material includes: geratology; stress and longevity; prevention of coronary thrombosis in physicians; congestive heart failure; venous pressure; home treatment of pneumonia; gastritis; gastrophotography; the kidneys during infections; logotherapy, mental hygiene, and psychotherapy. Preventive geriatrics is stressed.

The author states that the causes of aging are still obscure as are the causative factors of cancer; that when the aging processes will be fully clarified is still a matter of speculation, but it is now known that pathologic processes are often modified in senescence, and may present a different clinical picture in the aged than in younger persons. He also states that geriatrics is of national importance in wartime, since the aged when physically and mentally fit can substitute for the young absorbed into the Armed Forces.

This volume embodies not only the direct contributions of six authors, but also indirect contributions of many other physicians from various parts of the world who

(Continued on Page 20)

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BOOK REVIEWS

(Continued from Page 18)

have corresponded with the author and given him the benefit of their experiences of the past quarter century.

The Physiological Basis of Medical Practice. A University of Toronto Text in Applied Physiology by Charles Herbert Best, C.B.E., M.A., M.D., D.Sc. (Lond.), F.R.S., F.R.C.P. (Canada), Professor and Head of Department of Physiology, Director of the Banting-Best Department of Medical Research, University of Toronto, and Norman Burke Taylor, V.D., M.D., F.R.S. (Canada), F.R.C.S. (Edin.), F.R.C.P. (Canada), M.R.C.S. (Eng.), L.R.C.P. (Lond.), Professor of Physiology, University of Toronto. Fourth edition. Cloth. Price, $10.00. Pp. 1169, illustrated. Baltimore: The Williams and Wilkins Company, 1945.

The authors state that they have endeavored to write a book which will serve as a link between the laboratory and clinic and promote continuity of physiological teaching throughout the pre-clinical and clinical years of the under-graduate course, and that by stressing the principles underlying diseased states, medical students will be shown how knowledge of such principles will aid in the interpretation of symptoms and directing treatment.

Many physiological problems can be approached only through animal experimentation. Advances in many fields, most notably in those of carbohydrate metabolism, nutrition and endocrinology, bear witness to the fertility of this method of research. On the other hand, many problems can be elucidated only by observations upon man, and physiology has gained much from clinical research. Clinical research has not only revealed the true nature of the underlying process in disease, but has cast light into some dark corners of physiology as well.

During the last century, knowledge of the processes of disease was sought mainly in studies of morbid *anatomy,*

(Continued on Page 24)

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BOOK REVIEWS

(Continued from Page 20)

biochemistry being in its infancy and many of the procedures now commonly used for the investigation of the human subject not having been devised. Today, the student of scientific medicine is directing his attention more to the study of morbid *physiology* in an effort to solve clinical problems.

The authors, feeling that this modern trend in the field of research should be reflected in the teaching of medical students, have given greater prominence to clinical aspects of the subject than is usual in physiological texts.

In Hastings, Nebraska, the Chamber of Commerce got a simple, heart-warming request: "Please send me all the information you can. Thank you."—*Time.*

TWENTY-FIVE YEARS AGO

(Continued from Text Page 418)

tosis is a pathological condition and is not to be considered in any sense a disease entity. By ptosis is meant a downward displacement of an organ. One or several or all of the viscera may be affected by this condition. As a general rule it is safe to say that visceroptosis is secondary to some primary pathology. It is conveniently classified as hereditary and acquired. Just as an individual may be born with a deficient mental capacity, so from birth others are predisposed to a relaxed condition of the abdominal content. It is not difficult to recognize the type, but it is equally important for the patient's future well-being that an early recognition of this tendency be made. . .

Excerpt from "Chairman's Address—Section on Pediatrics California State Medical Society," by William

(Continued on Page 28)

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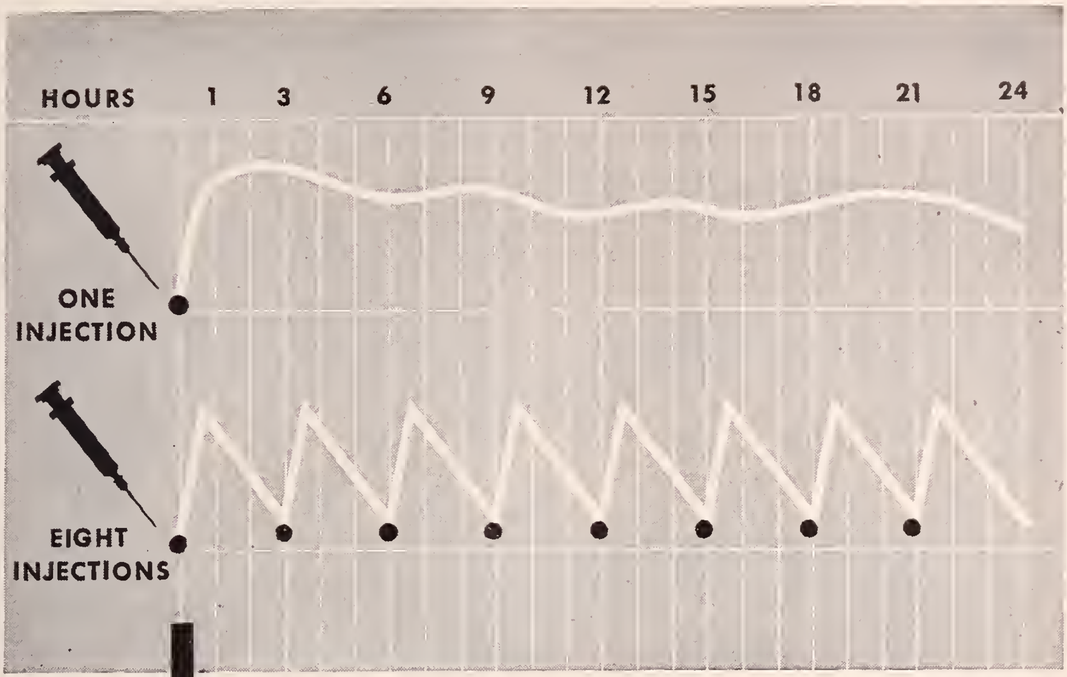

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TWENTY-FIVE YEARS AGO

(Continued from Page 24)

Palmer Lucas, M.D., San Francisco.—I wish to try to present to you today some idea of the growth of pediatrics and some of the problems which must be faced by those of us who are interested in its proper development. It is only a period of some twenty-five or thirty years since pediatrics was first recognized as a major department in the practice of medicine. Previous to that time, although there were many individuals who might be counted as specialists in the diseases of children and a considerable number of yearly publications on subjects related to pediatrics, yet there were very few of the representative schools in this country that had chairs of pediatrics. The first chair of pediatrics in this country was established by Dr. Abraham Jacobi in the College of Physicians and Surgeons in New York City. . . .

From an Article on "Problems in Plastic Surgery," by George Warren Pierce, M.D., San Francisco.—As with certain other surgical specialties, plastic surgery has shared in a distinct advancement due to the recent war. The urge of thousands of mutilated faces developed special plastic centers and grouped gifted surgeons, who revised the older methods and evolved new methods of plastic reconstruction. The writer spent some time at Queen's Hospital, the British center for plastic reconstruction, and had the privilege of working there with Mr. H. D. Gillies, whose genius and devotion to this subject have gone so far in solving the problems of plastic surgery. Observations of some of the methods in use at Queen's Hospital will constitute the major portion of this paper, together with the relation of these methods to civil surgery. . . .

(Continued in Back Advertising Section, Page 36)

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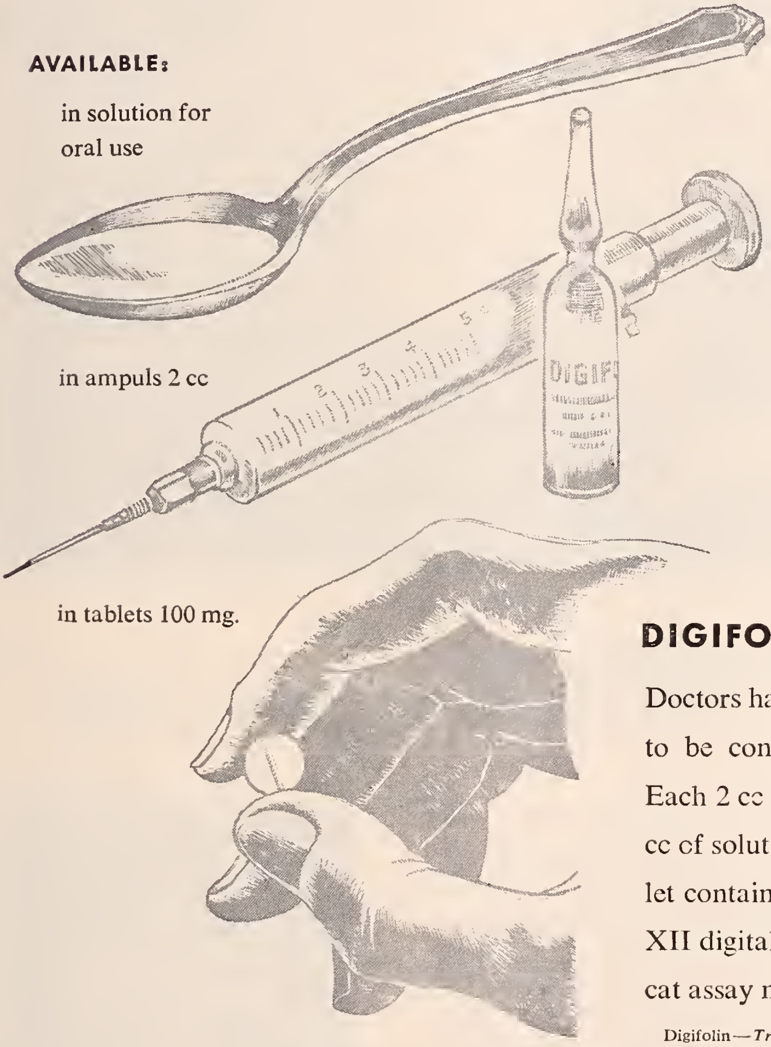

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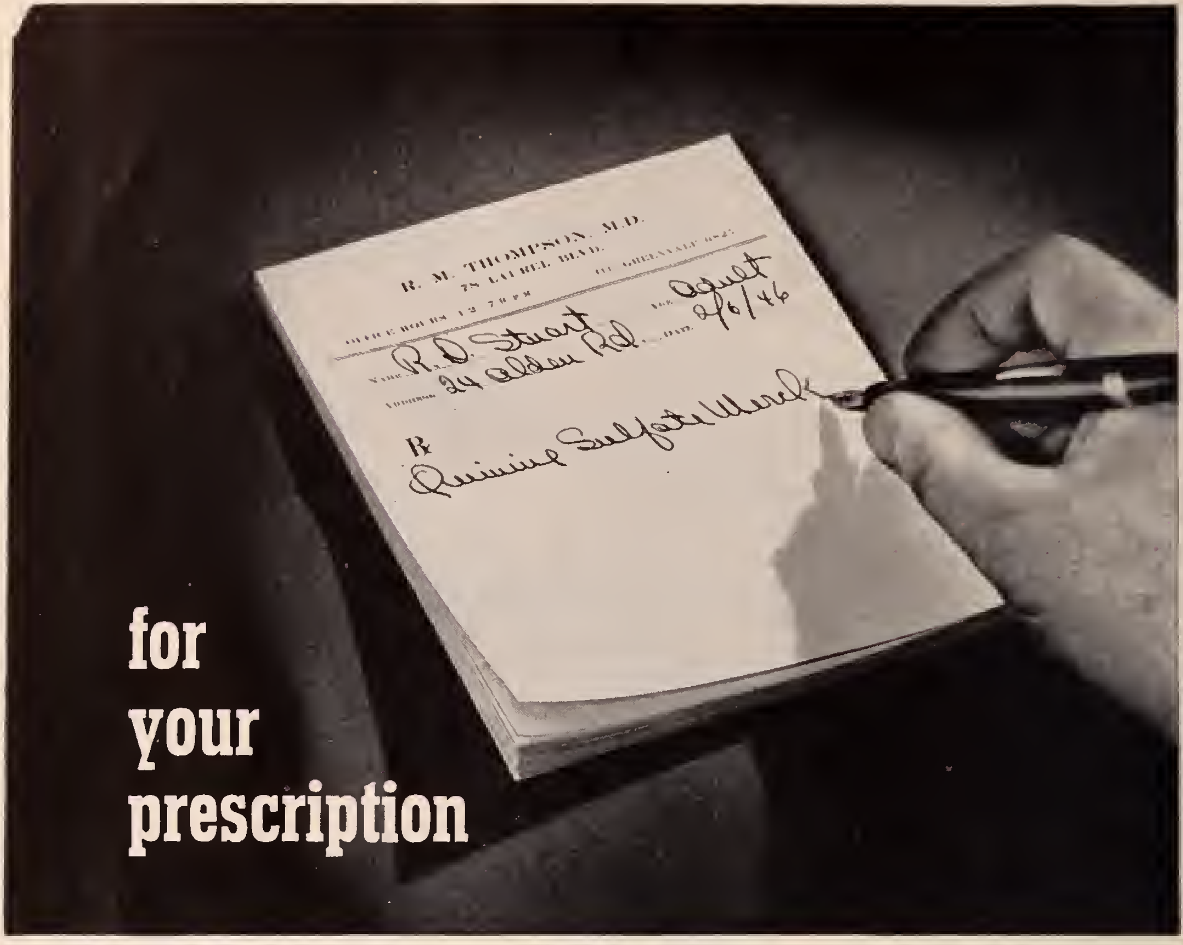

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Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

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R. H. Sundberg........................San Diego 1948
George W. Walker, Chairman..........Fresno 1949
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Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

John W. Cline

THE NEW PRESIDENT-ELECT

The post of President-Elect of the C.M.A., highest elective position decided each year, went this year to Doctor John W. Cline of San Francisco. For the benefit of those members not acquainted with their new President-Elect, a short biographical sketch is in order.

Born in Sonoma County, California, he attended public schools in California and took his A.B. degree at the University of California in 1921. His medical training was at Harvard University, where he obtained his M.D. in 1925. His final year was spent as an intern at the Faulkner Hospital, followed by the 1925-1927 period as house officer at Massachusetts General Hospital, Boston, and two additional years, 1927 to 1929, as a resident surgeon at Bellevue Hospital, New York City.

Doctor Cline established his practice in San Francisco, where he has continued in practice and where he has become an assistant clinical professor of surgery at Stanford University Medical School, assistant visiting surgeon at San Francisco Hospital and associate surgeon at Children's Hospital. During both his medical schooling and his active practice he has written scientific articles, his earliest dating back to 1925 and his latest appearing this year. At present he has a number of additional papers on surgical subjects in preparation.

Always a student of the economic side of medical practice, he has served as a director and as president of the San Francisco County Medical Society and has been an elected member of the C.M.A. Council since 1940. In the last-named capacity he has served as chairman of the Auditing Committee and chairman of the Executive Committee. Last year he served his first year as a Delegate to the American Medical Association.

Doctor Cline resides in San Francisco, is married and the father of three children.

ANNUAL SESSION HIGHLIGHTS

Elsewhere in this issue are printed the minutes and proceedings of the seventy-fifth annual session of the California Medical Association. They make interesting reading, important to all C.M.A. members.

Summarizing four days packed full of meetings, conferences and sessions is a task too severe for your editor but there are certain achievements which may be highlighted and pointed to with pride.

Among other things, this annual session (1) approved an official C.M.A. reorganization which provides for an expanded central office with officers serving on a part-time basis, (2) reindorsed the principle of advanced dues for the purpose of providing sufficient funds for an adequate public relations program, and (3) adopted a comprehensive report for the betterment of California Physicians' Service.

On the side of official organization, the Council adopted resolutions calling for the employment of an assistant Executive Secretary and several field secretaries. The House of Delegates approved the retirement of Doctor George H. Kress as Secretary-Editor, naming him Honorary Historian and Editor Emeritus after thirty-nine years of devoted service to organized medicine. His former duties in the C.M.A. office will be taken over by Dr. L. Henry Garland of San Francisco, appointed Secretary-Treasurer, and Doctor Dwight L. Wilbur of San Francisco, named Chairman of the Editorial Board and Editor of California and Western Medicine.

Election of officers for 1946-1947 saw Doctor John W. Cline of San Francisco elevated to the position of President-Elect, succeeding Doctor Sam J. McClendon of San Diego, who was installed as President at the closing session of the House of Delegates. Doctor E. Vincent Askey of Los Angeles was reëlected Speaker of the House of Delegates and Doctor Lewis A. Alesen was reëlected Vice-Speaker.

As Councilors, the House of Delegates reëlected Doctor Harry E. Henderson of Santa Barbara for the Third District and Doctor John W. Green of Vallejo for the Ninth District. For the Sixth District, San Francisco County, Doctor Edwin L. Bruck was chosen as Councilor after having resigned as Councilor-at-Large. His place as Councilor-at-Large was taken by Doctor H. Gordon MacLean of Oakland. Others elected in this capacity were Doctor C. V. Thompson of Lodi, succeeding Doctor Dewey R. Powell of Stockton, and Doctor Louis J. Regan of Los Angeles, succeeding Doctor Edward B. Dewey of Pasadena.

For Delegates to the A.M.A., Doctors H. Gordon MacLean, E. Vincent Askey, John W. Cline and Donald Cass were reelected. In addition, Doctor John W. Green was named an A.M.A. Delegate to succeed Doctor Dwight H. Murray, who resigned because of his election last year as a Trustee of the A.M.A.

As Alternates to the A.M.A., Doctors L. H. Fraser of Richmond, C. Kelly Canelo of San Jose and Ralph B. Eusden of Long Beach were reëlected and Doctor William Benbow Thompson of Los Angeles was chosen to succeed Doctor Donald G. Tollefson of Los Angeles. To succeed Doctor John W. Green, elevated to Delegate to the A.M.A., Doctor H. Randall Madeley of Vallejo was selected as Alternate.

Notable throughout the meeting was the air of agreement on the fundamental principle that medicine must lead the way in furnishing the public with the financial means of meeting unpredictable costs. The old arguments on the pros and cons of this question were not evident this year; the only questions were those on the methods to be employed. Scientific advances in medicine have long been taken for granted; now we see the recognition of economic advances.

The House of delegates, acting on the comprehensive report of the Chandler Committee, adopted new and wider avenues for California Physicians' Service to follow. At the same time, this action brought into greater prominence the desirable availability of C.P.S. to a greater segment of the population. The changes adopted, reported in other pages of this issue, indicate the desire of California physicians to devote their efforts to public service. Here at last is the ultimate recognition of the people as the master of medicine. Here is reiteration of the oft-expressed principle that what is good for the people is good for medicine.

WAGNER-MURRAY-DINGELL BILLS

Current comment on the 1946 versions of the Wagner-Murray-Dingell bills seems to indicate that this type of legislation will not be passed by the present session of Congress. The Senate version of the bills, S. 1606, is still in committee, where hearings have been held for the past two months; the House version has been held back, presumably for political reasons but probably because the House of Representatives would demand that such a measure go before its Ways & Means Committee, the one committee which considers all federal fiscal ideas. Let us not forget that all appropriations must originate in the House of Representatives.

Comes now the Taft Bill, S. 2143, introduced by Senator Taft of Ohio with the blessings of Senators Smith and Ball. This measure proposes that the Federal Government lend its financial support to the forty-eight states, on a matching basis, for the provision of voluntary hospital and medical care insurance for medical indigents. Hearings on this bill will probably be held before Congress adjourns this July; in any event, word comes that witnesses for or against the Wagner-Murray-Dingell bills are to be asked by Senator Murray's committee to be prepared to testify not only on S. 1606 but also on S. 2143.

Even if these two measures are both lost, which now appears likely, the message is clear: Government will provide a system of medical care for the people if medicine does not do so. If Congress does not enact some form of legislation in 1946, it will be asked to do so again in 1947. Eventually there is nothing to look forward to but *some* new law on the books, be it compulsory health insurance or voluntary.

There is no choice between the two. The answer is clear. Only one element remains: Time is short.

YOUR JOURNAL

California and Western Medicine has lived a long and successful life. It has weathered various changes of Association administration, has outlived several editors who have contributed to its success, and has even gone through changes of name. Now we come to a new fork in the road, a new point of departure from former expectations.

Inherent in the deliberations of the 1946 Annual Sessions of the C.M.A. was the desire to struggle free from former bounds and to achieve, in one leap, the long step to modern times, modern ideas. California and Western Medicine is prepared to take this step.

Under the editorial supervision of the Chairman of the Editorial Board, and under the productive guidance of the central office staff, your journal proposes to modernize itself, to make such changes as seem desirable. Hope springs eternal and it is hoped that our readers will approve.

In the months to come, don't be surprised to see something new or something different. If a name is changed here, or a section there, we hope it is in the interest of providing our readers with something palatable if not succulent. Throughout this process, the one guiding force will be to furnish California physicians with a journal of which they may be proud, written and prepared in the best traditions of modern medical practice and presented in a form which hopes to be, at one time, interesting, instructive and attractive. Your comments are invited and will go a long way toward determining the ultimate form of your journal. The editors pledge themselves to this end, never forgetting that this is *your* publication.

THE DIAGNOSIS OF TUMORS

Since the turn of the century tumors have been diagnosed at much earlier stages, thus making obsolete most of the diagnostic criteria previously employed, and at the same time necessitating ever changing reorientation as regards our present diagnostic methods. Fortunately, due in no small part to the lay educational program of the American Cancer Society, patients in some localities are coming to their doctors with much smaller and earlier cancers than they did thirty years ago. The signs and symptoms of these smaller cancers are not those commonly described in text-books. The advanced cancer seen at the post-mortem table is not always the picture seen by the patient's family physician and by the surgical pathologist. Progress in the early recognition and detection of cancer is dependent upon the realization that in spite of "danger signals" there are no characteristic signs and symptoms which are pathognomonic of early cancer. A *complete physical examination* and various accessory diagnostic procedures are helpful and important. However, it must be emphasized that the only means of definitely establishing the diagnosis of cancer is by the *histological study* of suitable tissue under the microscope by a competent pathologist who is qualified in the problems of oncology.

In spite of the fact that cancer is being diagnosed earlier, there is still much regrettable and needless delay. With carcinoma of the large bowel, for example, this point is well emphasized in a recent study by Scarborough[1]. Even though the patients (private and clinic) in his series had had symptoms referable to the large bowel for an average of eight months before they received definite treatment, physicians allowed four and one-half months to elapse before establishment of a correct diagnosis. It is still commonplace for a patient with rectal cancer to present himself with the story of having already been examined and treated by from one to four doctors for "hemorrhoids."

Early detection and correct diagnosis of cancer are essential if the cancer problem is to be successfully attacked. A serious bottleneck in the attack is the shortage of competent pathologists. The laudable attempts by the American Cancer Society and other agencies to encourage the establishment of cancer clinics are greatly handicapped by this shortage. There is real danger that as a result of this shortage inadequately trained pathologists or other medical men will be entrusted with that most important of responsibilities,—the making of tissue diagnoses. The medical profession at large often fails to remember that the pathologist is a physician, practicing diagnostic medicine, and frequently the most important cog in the final diagnosis of tumors. This indifference, plus the fact that hospitals tend to "hire" pathologists on salaries contributes in no small part to the unsatisfactory shortage of competent tissue pathologists. There is at present little inducement for any capable physician to take up pathology, even as a temporary occupation; if surgeons faced a similar salaried status in private hospitals, there would be a similar shortage of these specialists. To reiterate, the diagnosis of cancer often requires skill not only on the part of the pathologist but also on that of the tissue technicians whose responsibility it is to prepare the slides from which the diagnoses are made. Too often, histological sections are so poor they do not permit of a diagnosis. Insistence on the histological evaluation of the growth capacities and estimated radio-sensitivity of tumors, and the correlation of tumor structure with the clinical picture, has added another burden to the untrained pathologist. If he cannot differentiate between an endometrial hyperplasia and a corpus carcinoma how can he evaluate the lesion? Competent pathologists are not made to order in a few months.

If the benefits of popular education are to redound to the direct advantage of the patient, prompt and accurate diagnosis is necessary. Often this necessitates a biopsy. Careful clinical and experimental studies have shown that there is less hazard to a biopsy properly performed with a clean incision, than there is to repeated palpation.

Since tissue examination may be the most important single procedure in the establishment of a diagnosis of cancer, there are a number of working rules which should be followed. Prebiopsy x-ray irradiation and cauterization is usually inadvisable. Radical, mutilating operations should never be done for cancer without tissue diagnosis. In the diagnosis of Hodgkin's disease and other lympomatoid dyscrasias it is especially desirable that biopsy be performed prior to therapy. Otherwise, one may not be certain of the diagnosis, and the ultimate results of therapy may be difficult to judge. A fair-sized node should be removed, since the small "satellite" nodes near the periphery not infrequently show merely non-specific inflammatory changes, making it necessary to subject the patient to the inconvenience of a second biopsy procedure. For purposes of biopsy it is preferable to secure non-irradiated lymph nodes. Lymph nodes should be sectioned and immediately preserved in proper fixative. The histological features of Hodgkin's disease cannot be identified in poorly prepared tissue.

Adjuncts in the diagnosis of cancer cover a multitude of useful procedures. Not infrequently, the diagnosis of tumor can be made by the examination of centrifuged sediment of body fluids and secretions. Punch and aspiration biopsy can be judiciously used in selected cases. Certain biologic tests, such as the Friedman and Ascheim-Zondek tests, on blood and urine may reveal the presence of hormone secreting tumors,—such as choriomas, malignant testicular tumors and granulosa cell tumors of the ovary. Phosphtase determinations (alkaline and acid) in cases with bone lesions may give valuable information in revealing or excluding metastatic carcinoma of the prostate.

Under suitable circumstances a biopsy can be safely done, and is usually essential for diagnosis. Its value far outweighs the danger to the patient. Its importance in directing the indication for and scope of surgery and irradiation is being more and more recognized by the medical profession. Its usefulness in the early detection and control of cancer will be tremendously expanded by your encouraging and development of and the support of trained pathologists.

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EDITORIAL COMMENT[†]

"BLOCKING" ANTIBODIES

In 1921 Coca[1] of Cornell University reported that at times an immune serum prepared by repeated injection of one strain of B. influenzae into rabbits would agglutinate several others strains of the influenza bacillus but was inactive against the specific strain used for immunization. Tests showed that this negative reaction was due to the dominance in the immune serum of a specific inhibitory factor. This factor was found to be relatively unstable, and to disappear almost quantitatively by the end of 50 days storage with full release of its previously inhibited agglutinating function.

A somewhat similar observation was made at a later date, by Yanagihashi[2] of the Tohoku Imperial University, Japan. The Japanese investigator found that when rabbits are immunized by repeated injections with Forssman antigen or with alien red blood cells the production of serum hemolysins rises to a maximum by the end of about three weeks and then invariably falls. In extreme cases the terminal hemolytic titer is but one-hundredth of the fourth week maximum titer. He found that immune serums whose initial hemolytic titers had thus dropped were capable of strongly inhibiting the hemolytic action of other hemolytic antiserums.

To account for this phenomenon, Yanagihashi assumed that following injection of Forssman antigen or alien red blood cells the fixed cells of the injected animal liberate a specific hemolytic amboceptor. As soon as this amboceptor reaches a sufficiently high titer it functions as an alien colloid, giving rise to a secondary wave of specific antibodies or specific anti-amboceptors. On prolonged immunization the secondary anti-amboceptor became dominant, thus preventing hemolytic action. His studies of the thermostability and specific absorption of the inhibiting factor seemed to confirm this theory.

Tanagihashi's work was of theoretic interest at the time, since it offered a plausible explanation for a number of paradoxical phenomena reported by earlier investigators, and also offered a plausible explanation for the "prozone phenomenon" with specific agglutinating serum. His theory, however, has recently become of practical clinical interest, on account of its bearing on certain diagnostic paradoxes and on toxicities resulting from transfusion from Rh-positive donors.

[†] This department of CALIFORNIA AND WESTERN MEDIICNE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

It was noted by Wiener[3], Levine[4] and others that there are many Rh-negative patients who are strongly sensitive to the Rh-positive corpuscles, yet whose serum does not contain demonstrable Rh-agglutinins. These non-agglutinating serums often contain a large amounts of anti-agglutinin or inhibiting factor, capable of "blocking" or otherwise preventing agglutination of Rh-positive corpuscles[5]. It was found that while the serum of certain patients contained demonstrable Rh agglutinins six days after delivery of an erythroblastic infant, their serums often became negative three weeks later. At this time the serum may have contained dominant amounts of "blocking" or inhibiting antibody. A rapid slide test for the titration of this "blocking" factor was afterwards developed by Diamond[6] and his associates of Harvard University and modified as a test tube reaction by Wiener[7] of the Jewish Hospital of Brooklyn, and by Levine[5] of the Ortho Research Foundation, Linden, N. J.

Numerous theories have been proposed to account for the nature of these "blocking" antibodies. Among them are the assumption that they are incomplete, immature or degenerated Rh agglutinins. To form a factual basis for the development of a future theory, Witebsky[8] and his associates of the University of Buffalo, developed a simple method for the concentration of separation of Rh agglutinins and anti-agglutinins. Native serum was dialyzed at 40°C for 24 to 30 hours in a cellophane bag against several changes of distilled water. The resulting precipitate was freed from the supernatent by centrifugation, and then dissolved in one-tenth of the original serum volume of saline solution. It was found that the resulting globulin solution contained the major portion of the Rh agglutinin. The "blocking" antibody remained almost quantitatively in the supernatent fluid, which contained the albumin fraction of the original serum. Witebsky presents this new technique as a simple method for the producing of potent Rh-diagnostic serum from native Rh-anti-serums of such low titer as to be of no practical clinical value.

A plausible explanation for his data would be the assumption that in response to the presence of Rh-positive corpuscles in a Rh-negative individual, two specific antibodies are formed. One of these, the primary antibody, would be an agglutinating globulin. The other (or secondary) antibody would be a non-agglutinating albumin. Both antibodies would have a specific affinity for Rh-positive corpuscles. Union of the non-agglutinating albumin with Rh-corpuscles might "block" subsequent union with the active agglutinin. Other explanations are of course possible.

That multiple antibodies may be formed against certain "polyhaptenic" antigens is now well recognized by immunologic theorists[9]. Certain "univalent" antibodies are known to be nonagglutinating and nonprecipitating in routine in vitro tests[10]. Whether or not there is a similar dual or multiple antibody formed in response to injection of other blood types has not yet been determined. The bearing of this work on general allergic theory also has not yet been determined.

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Pfeiffer's Disease.—Emil Pfeiffer was born in Wiesbaden; here, too, he lived and died. His medical studies took him to Bonn, Würzburg, and Berlin, where he graduated in 1869. After settling in Wiesbaden, he became instrumental in its development as a health resort. As a matter of fact, he was one of the outstanding German spa doctors and published many works on the theme of metabolic illnesses. His name survives in the eponym for glandular fever, "Pfeiffer's Disease."—Warner's *Calendar of Medical History.*

William Blake (1757-1827).—The forebodings and illusions with which William Blake was troubled present an interesting study in neuropsychiatry. His art and writings transmit, by their very strangeness, the visionary aura which he claimed to possess. Ill health, poverty and neglect were his lot. Yet this creative poet-painter held imaginary discourses with such as Swedenborg, Milton and Dante; biblical personalities posed for him, he witnessed the funerals of fairies—and was happy in his world of substitute reality.—Warner's *Calendar of Medical History.*

Friedrich W. Nietzsche (1844-1900).—Always an invalid, Nietzsche's mental abnormalities and final madness can probably be ascribed to an overactive brain abused by overwork and narcotics. The gradual transitional changes in his mental state are traceable in his writings. What apparently was his first attack of violent mental derangement occurred at Turin. He fell down at the gate of his house, powerless to rise unaided. After a lethargic spell, he spoke and sang noisily, and paid for trifles with large sums of money.—Warner's *Calendar of Medical History.*

ORIGINAL ARTICLES

Scientific and General

ELECTROCARDIOGRAPHIC ABNORMALITIES IN 6,000 CASES OF RHEUMATIC FEVER*

Lt. Comdr. Milton B. Filberbaum (MC), U.S.N.R.
Lt. Comdr. George C. Griffith (MC), U.S.N.R.
Comdr. Robert F. Solley (MC), U.S.N.R.
and
Capt. William H. Leake (MC), U.S.N.R.
Los Angeles

The segregation of a large number of patients with rheumatic fever in a Naval Hospital afforded an unusual opportunity to observe the electrocardiographic abnormalities associated with this disease. Studies of this nature have frequently appeared in the literature.[1, 2, 3, 4] However, it is our belief that no similar large number of patients with this disease has been studied over so short a period of time. A further point of interest in the present study is the fact that all our patients were young adults, whereas previous studies included a large preponderance of children.

MATERIAL

Over a period of approximately one and one-half years, from the latter part of 1943 to the early months of 1945, 6,000 patients with rheumatic fever were observed at this activity. All but a negligible proportion were males, ranging in age from seventeen to the middle forties. The overwhelming majority of the patients were between the ages of seventeen and twenty-five. When first observed by us they were in various stages of rheumatic activity. Relatively few were seen in the first weeks of their disease and many were not seen for several months after the inception of their illness. This probably accounts for the low incidence of electrocardiographic abnormalities observed by us as compared with those reported in the studies previously cited. The degree of activity of the rheumatic process ranged from the acute fulminating to the almost completely quiescent. As soon as possible after receipt at this activity, usually within the first twenty-four to forty-eight hours an electrocardiogram was taken on each patient. Subsequent tracings were taken as indicated, in accordance with the degree of activity of the disease, the presence of previous electrocardiographic abnormalities and the suspicion of renewed rheumatic activity. The total number of electrocardiograms thus obtained in this group of patients was 9,634. The criteria of the American Heart Association for the interpretation of electrocardiograms were fairly uniformly observed. Those interpreted as indicating deviations from the normal were reëxamined and reevaluated before inclusion in the present study. Of the total thus reviewed 898 patients were found to have changes which warranted inclusion in the present summary. Any references to the clinical findings in these patients are of a most general nature. It is hoped that a more specific correlation of the individual types of abnormality with the clinical findings may be undertaken at a future date.

DISTURBANCES OF RHYTHM

Sinus tachycardia, sinus bradycardia and sinus arrhythmia, while frequently observed, were not considered of sufficient significance to be included in the present study. The accompanying table (Table 1) lists the disturbances of rhythm found in the group under consideration. It is noted that the total incidence of premature beats was no greater than that observed by Graybiel, McFarland, Gates and Webster,[5] in a group of normal aviators in the same age group. However, these observers noted no instances of auriculo-ventricular nodal premature contractions. The occurrence of this abnormality in 18 of our patients appears therefore to be of some significance.

Auricular tachycardia, auriculo-ventricular nodal tachycardia and auricular fibrillation all of the paroxysmal type have previously been noted in the presence of acute rheumatic fever.[1] These abnormalities were observed in 7 of our patients.

The interesting type of arrhythmia known as interference dissociation, or parasystole was observed in four instances in our present series (Figures 1 and 2). Since completion of this study several additional instances of this type of abnormality have been observed. The occurrence of this type of arrhythmia, of A-V nodal premature contractions, nodal rhythm, nodal tachycardia and ventricular escape to the extent observed by us appears to indicate a heightened irritability of the auriculo-ventricular node in some cases of rheumatic fever. It will be noted that in lead 3 of Figure 1 nodal tachycardia supervened, further stressing this impression.

Table 1.—*Arrhythmias*

	Patients
1. Sinus Arrest	2
2. Auricular Premature Systole	18
3. Auricular Tachycardia	1
4. Auricular Fibrillation	4
5. Wandering Pace Maker	10
6. A-V Nodal Premature Systole	18
7. A-V Nodal Rhythm	1
8. A-V Nodal Tachycardia	2
9. Ventricular Escape	4
10. Retrograde Auricular Contractions	6
11. Ventricular Premature Systole	49
12. Parasystole	4

Another interesting arrhythmia encountered in six in-

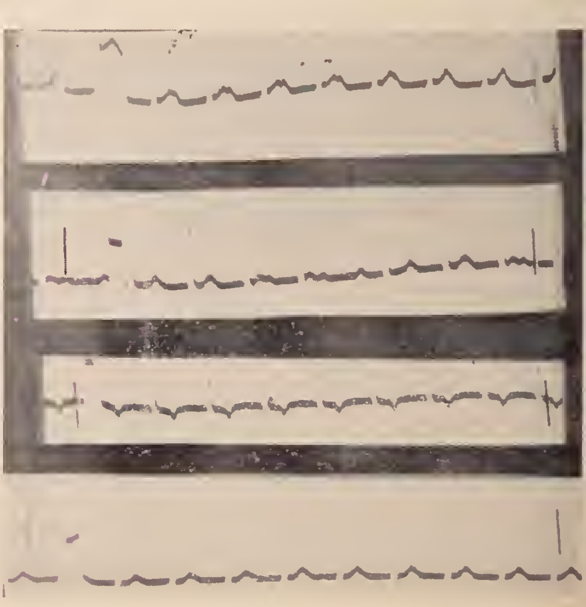

Fig. 1.—Parasystole. Nodal Tachycardia in Lead III.

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* This article has been released for publication by the Division of Publications of the Bureau of Medicine and Surgery of the U. S. Navy. The opinions and views set forth in this article are those of the writers and are not to be considered as reflecting the policies of the Navy Department, or the military service at large.

From the Rheumatic Fever Unit, U. S. Naval Hospital, Corona, Calif. Research Project X-513g.

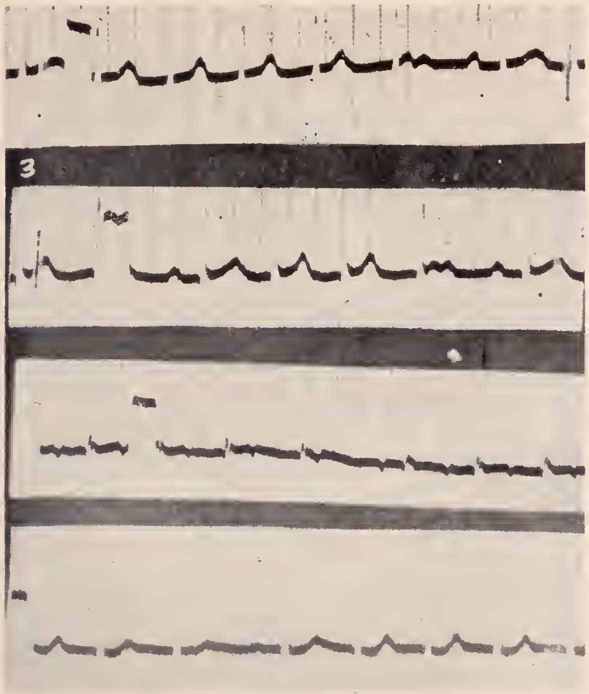

Fig. 2.—Parasystole.

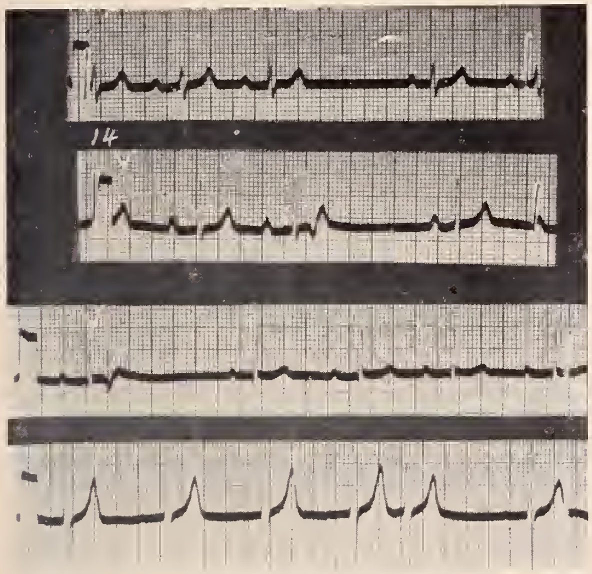

Fig. 3.—Retrograde P Waves. Followed by Dropped Beats.

stances is shown in Figures 3 and 4. This is characterized by the appearance of retrograde P waves following the usual P and QRS complexes. These retrograde P waves evidently occur at a time when the ventricle is refractory and therefore no ventricular contraction is noted to follow. This type of abnormality usually occurred in the presence of a prolonged PR interval. The occurrence of this type of disturbance may also point to increased irritability of the A-V node, with the impulse traveling in both directions after reaching the node. The auricle alone responds since the previous delay in auriculoventricular conduction has permitted the auricle to again become responsive to stimulation.

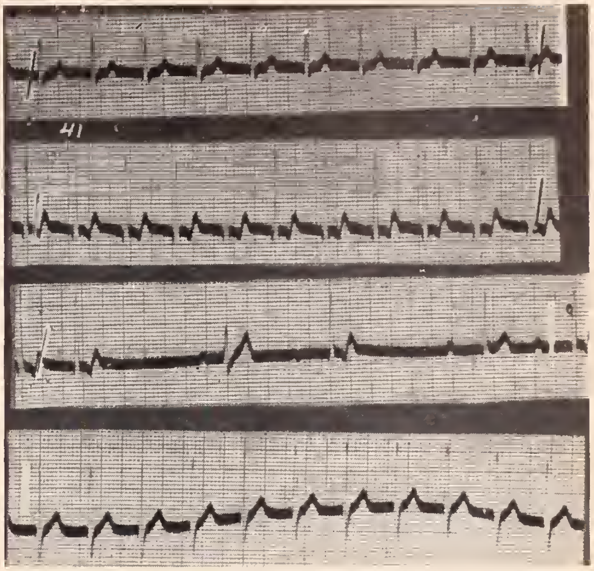

Fig. 4.—Nodal Tachycardia. Lead III shows return to basis sinus rhythm with prolonged P-R Interval, retrograde auricular contractions and dropped beats. Reversion to nodal tachycardia in Lead IV.

P WAVES

Changes observed in the P waves are summarized in Table 2. Only gross abnormalities were included in the study. Frequent marked changes in the P waves were observed in this group in successive tracings. Inversion of the P waves in leads I and II is probably a result of a shift of the site of the pacemaker in and away from the sinoauricular node. At the termination of rheumatic activity, these inverted P waves almost invariably became upright. Significant notching or inversion of the P waves, particularly in leads I and II, and especially when associated with changes in serial tracings appears to be definite evidence of rheumatic cardiac involvement. One interesting type of P wave change observed in several instances was a progressive shift in the P waves from the upright to the inverted position in one or more leads, indicating a marked progressive shift of the pacemaker.

TABLE 2.—*P-Wave Changes*
98 Patients (1.63%)

Leads	High	Notched	Inverted
I	3	11	9
II	18	28	18
III	..	10	20
IV	..	12	..

P-R INTERVAL

The P-R interval was determined to the nearest .02 second. Prolongation of the P-R interval has long been recognized as one of the commonest abnormalities found in rheumatic fever. As noted in Table 3, 325 patients (5.01 per cent) demonstrated this finding. Only the highest P-R interval observed in any one patient was included in the table. The vast majority of all patients in this group showed P-R intervals of .22 to .26 seconds.

TABLE 3.—*Conduction Disturbances*

Prolonged PR-Interval 325 Patients (5.01%)	Patients
1. Group with .22 to .26 sec. PR-Interval	257
2. Group with .28 to .32 sec. PR-Interval	48
3. Group with .34 to .42 sec. PR-Interval	20
4. Premature P-Waves without Ventricular Response	8
5. Wenckebach Phenomenon	4
6. Complete AV-Block	1
Other Conduction Disturbances	
1. QRS-Interval Prolonged	7
2. Left Bundle Branch Block	2
3. Right Bundle Branch Block	4
4. Wolff-Parkinson-White Syndrome	4

However, very prolonged conduction times were observed in a significant number of individuals. In successive tracings on individual patients the P-R interval varied upward and downward and often within wide limits. In most instances the P-R interval returned to normal with the cessation of rheumatic activity. However, in many cases prolonged and even markedly prolonged P-R intervals persisted throughout long periods of observation, and even after clinical and laboratory evidence of disease activity had long since disappeared. It is possible that fibrotic changes occur in the conduction system in some patients resulting in a permanent delay in A-V conduction. It certainly seems evident that mere prolongation of the P-R interval, however great, cannot be interpreted as evidence of rheumatic activity. It was at first assumed that a changing P-R interval in successive tracings was indicative of an active process in the heart. However, moderate and even marked changes in the P-R interval were noted in some instances where quiescence of rheumatic activity seemed unquestioned. Further, several patients with normal hearts and no history of recent or old rheumatic activity have been observed by us to show marked prolongation of the P-R interval with marked changes in successive tracings. It is possible that vagal influences may be responsible for these variations in A-V conduction. Recent work by Gubner, Szucs and Ungerleider[6] appears to demonstrate that vagal influences are more marked in the presence of active rheumatic fever. These investigators have shown that a large preponderance of their patients with active disease and borderline A-V conduction showed an increase in the P-R interval following the administration of prostigmine and pressure on the left carotid sinus. It is possible that the use of this latter procedure may serve as a diagnostic measure for the differentiation of the active from the inactive cases in the group with persistent prolongation of the P-R interval. However, the frequent spontaneous changes in A-V conduction noted in our patients in this group might tend to somewhat diminish the value of this procedure. We have as yet had no opportunity to investigate this problem. It seems likely, however, that the decision as to the continuance of rheumatic activity cannot be predicated upon the observation of prolonged or changing P-R interval alone. An interesting variation of the delay in A-V conduction is the progressive prolongation of the P-R interval with eventual dropped beats (Wenckebach phenomenon). This was observed in four of our patients. One such instance is illustrated in Figure 5. Complete heart block was noted in only one patient and seems to be of relatively uncommon occurrence.

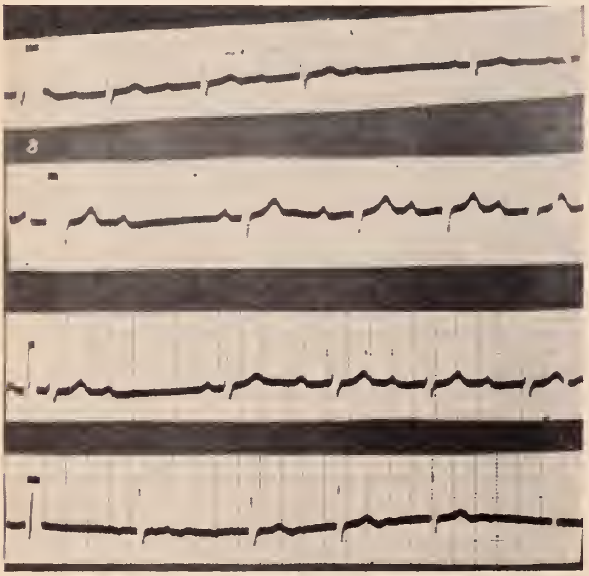

Fig. 5.—Progressive Prolongation of P-R Interval with Dropped Beats (Wenckebach Phenomenon).

OTHER CONDUCTION DISTURBANCES

Widening of the QRS complex was noted in 7 patients. This is well within the limits of normal for individuals in this age group[5] and cannot be considered of great significance. Left bundle branch block was observed in two patients and right bundle branch block in four patients (Figure 6). It is possible that the occurrence of this abnormality was purely coincidental. However, it is also possible that involvement of one or the other branch of the bundle by the rheumatic process might result in this type of abnormality. In all instances observed by us, bundle branch block persisted throughout the period of observation and long after all evidence of rheumatic activity had ceased. It is therefore not possible to determine whether the occurrence of bundle branch block in these patients was due to rheumatic involvement.

The syndrome of short P-R interval with wide QRS as observed by Wolff, Parkinson and White[7] was noted in four patients in the group under study. Two of these are shown in Figures 7 and 8. Several additional cases of this type were noted since termination of this study. This interesting abnormality is believed to be due to passage of the conduction impulse through a congenital aberrant conduction bundle between one auricle and ventricle. Its occurrence in rheumatic fever may be purely coincidental. However, recent investigations suggest grounds for speculation as to its specific importance when observed in rheumatic fever patients. It has been shown that digitalis and cholinergic drugs, due to their depressant action on the A-V node have the ability to produce this abnormality in individuals who have this type of congenital bundle.[8] In such cases the aberrant bundle, being unaffected or less affected by these drugs continues to function and reproduces the abnormal pattern. This

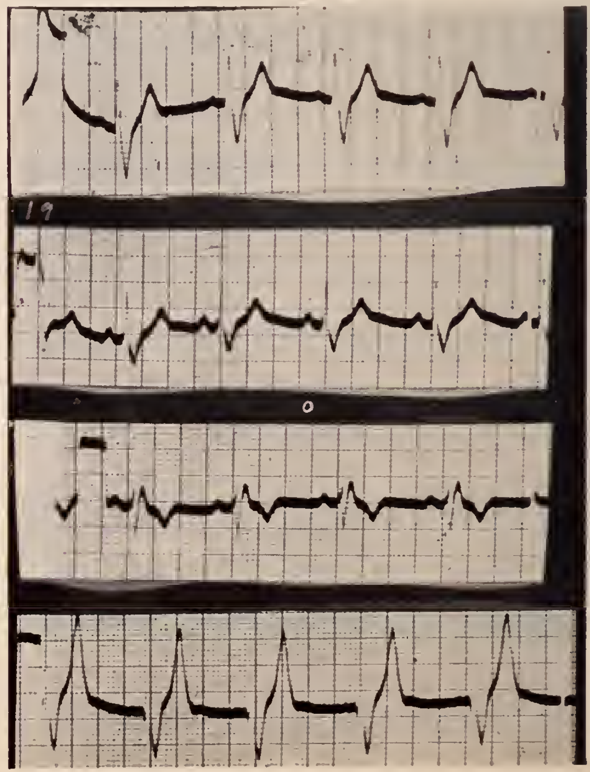

Fig. 6.—Right Bundle Branch Block.

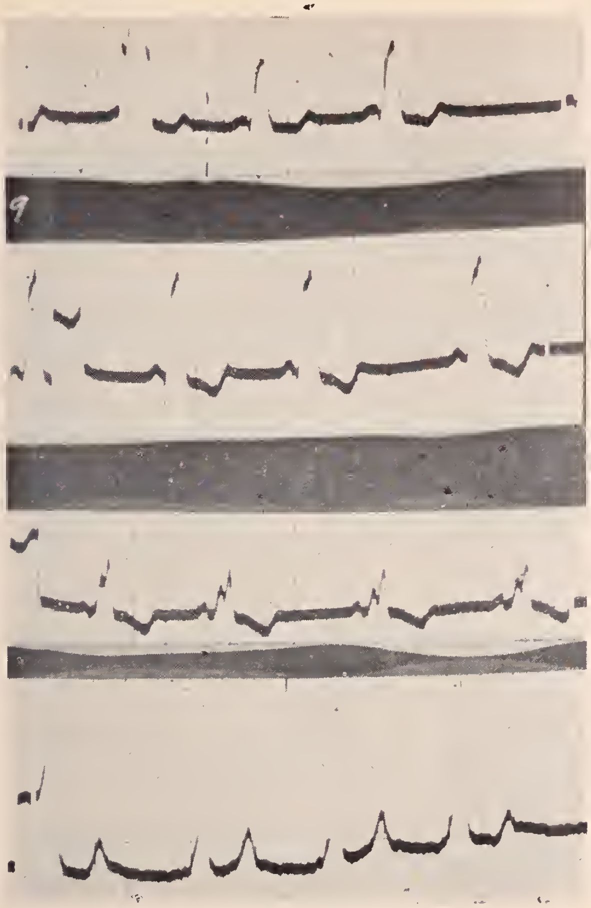

Fig. 7.—Short P-R with Wide QRS Complex.

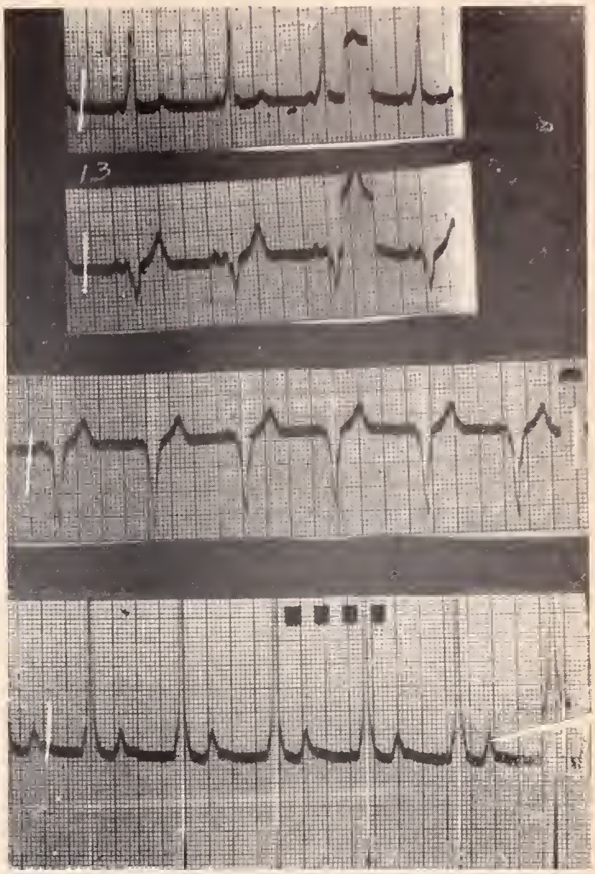

Fig. 8.—Short P-R with Wide QRS Complex.

suggests the possibility that rheumatic fever through its ability to interfere with conduction through the normal pathway may be capable of producing this type of abnormality in individuals in whose hearts such an aberrant conduction bundle exists. This supposition is in part supported by observation of one patient whose electrocardiographic pattern showed a tendency to shift from the normal to the abnormal type at various stages of rheumatic activity. This possibility is under further investigation.

THE ELECTRICAL AXIS

Deviation of the electrical axis to the left was noted in 318 patients and right axis deviation in 85 patients. Since this is within the limits of normal for individuals in this age group, no particular significance can be attached to this type of change. Variations in the electrical axis in subsequent tracings were rarely noted and never marked.

QRS COMPLEX

Other changes in the QRS complex are listed in Table IV. Only gross changes of the types enumerated were believed to be sufficiently significant to warrant inclusion in the table. They were found to occur in an insignificant proportion of the total studied. The presence of a deep Q wave in lead III as observed by Pardee[9] was noted in eight instances. Low voltage of QRS was observed in fourteen cases and is probably of some significance in patients in this age group. Slurring, notching and splintering of the QRS complex to a significant degree were of relatively infrequent occurrence.

ST JUNCTION

Abnormal displacement of the ST junction has been observed to be one of the commonest findings in acute rheumatic fever.[4] This is particularly true in the presence of acute pericarditis when the ST junction may be elevated in all leads with gradual return to the isoelectric line in conjunction with gradual inversion of the T waves.[10] In our series, abnormal displacement of the ST junction was noted in 74 patients (1.23 per cent) as listed in Table 5. In rare instances was the succession of changes noted by Bellet and McMillan[10] observed, although many instances of clinical acute pericarditis occurred among our patients. On the contrary in almost all of our patients in this group the deviation of the ST junction showed a tendency to constant displacement and rarely returned to normal. Since displacement of the ST junction has been shown to occur in at least as high a proportion of normal young adults as in those observed by us, the significance of this finding in the absence of other abnormalities seems doubtful. A fixed deviation of the ST junction, in the absence of T wave changes or other abnormalities does not appear to be of particular significance, at least in the present study. Other electrocardiographic changes associated with abnormalities of the ST junction are also noted in the table. In these patients at least, it seems likely that the associated changes are more significant than the deviations of the ST junction.

TABLE 4.—*QRS-Changes*

	Patients
1. Left Axis Deviation	318
2. Right Axis Deviation	85
3. QRS Low Voltage	14
4. Q-1 Deep	1
5. Q-2 Deep	2
6. Q-3 Deep	8
7. R-4 Absent	1
8. QRS Slurred, Notched, Splintered	11

Table 5.—*ST-Junction Abnormalities*

74 Patients (1.23%)		
Lead	Elevated	Depressed
I	14	3
II	48	5
III	23	6
IV	13	2
ST Changes with Prolonged PR-Interval		24
ST Changes with Prolonged PR-Interval and Abnormal T Waves		5
ST Changes with Abnormal T Waves		23

T WAVES

The presence of T wave abnormalities has been noted in from 3 to 40 per cent of all patients with rheumatic fever.[4] Pardee[8] states that if frequent serial tracings are recorded during the acute phase of rheumatic activity, as many as 60 per cent of all cases will be found to show inversion or some other abnormality of the T wave. Of our patients 125 (2.08 per cent) showed the T wave abnormalities listed in Table VI. Changes in T_3 alone when not associated with T wave abnormalities in other leads, were not considered significant and were not included in the table. It was believed to be of some value and interest to note the correlation of T wave changes in the various leads as listed in Table VII. Examples of some of the changes observed are seen in Figures 9, 10, 11, 12 and 13. Successive tracings on individual patients showed variations in this pattern and all these are included in the table. It is noted that changes in T_4 alone were most common, changes in T_2 and T_3 next in order of frequency and T wave changes in all four leads next in order of incidence. It has been previously observed that the succession of changes noted by Bellet and McMillan in cases of acute pericarditis were rarely observed among our patients. While the T wave abnormalities changed in successive tracings they did not necessarily revert to normal even upon complete subsidence of the acute rheumatic infection. Curiously, relatively few of those with persistent T wave abnormalities displayed any evidence of clinical heart disease. For example the patient from whom the tracing in Figure 13 was obtained was entirely quiescent by all clinical and laboratory criteria. Physical examination of the heart was entirely normal. However, he continued to display the same abnormality with but slight variation throughout a long period of observation. Upon discharge from treatment the electrocardiogram was about the same. It is suggested that alterations in the T waves, while evidence of cardiac involvement during the acute phase of rheumatic fever, cannot be used to estimate continuance of rheumatic activity. The observation of isolated and often long continued inversion of T_4 suggests the possibility that the finding of this type of abnormality in apparently healthy individuals with normal hearts may be an indication of antecedent rheumatic infection.

Table 6.—*T-Wave Changes*
125 Patients (2.08%)—268 Tracings

Lead	Low	Diphasic	Inverted
I	47	18	15
II	38	36	36
III	21	14	56
IV	26	37	52

Table 7.—*Association of T-Wave Abnormalities*

	Tracings
1. T-1 Alone	10
2. T-2 Alone	79
3. T-4 Alone	79
4. T-1, T-2 Combination	9
5. T-1, T-3 Combination	1
6. T-1, T-4 Combination	17
7. T-2, T-3 Combination	64
8. T-2, T-4 Combination	5
9. T-3, T-4 Combination	1
10. T-1, T-2, T-3 Combination	13
11. T-2, T-3, T-4 Combination	8
12. T-1, T-2, T-4 Combination	5
13. T-1, T-2, T-3, T-4 Combination	45

DISCUSSION

The electrocardiogram is a valuable adjunct in the diagnosis and treatment of rheumatic fever. However, its limitations are indicated by some of the findings in the present study. While prolongation of the P-R interval is a very significant observation in the diagnosis of rheumatic fever in suspected cases, as an isolated finding its significance is in doubt. Furthermore, as a guide to activity of the rheumatic process, its value is also

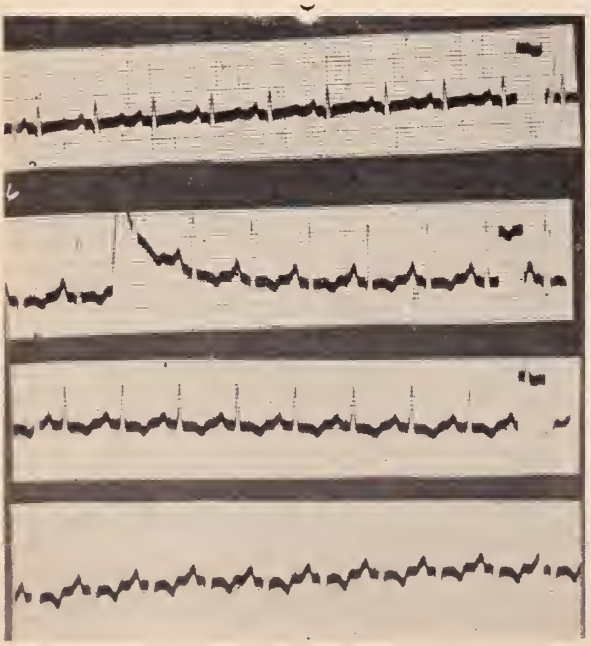

Fig. 9.—Inversion of T_2, T_3 and T_4.

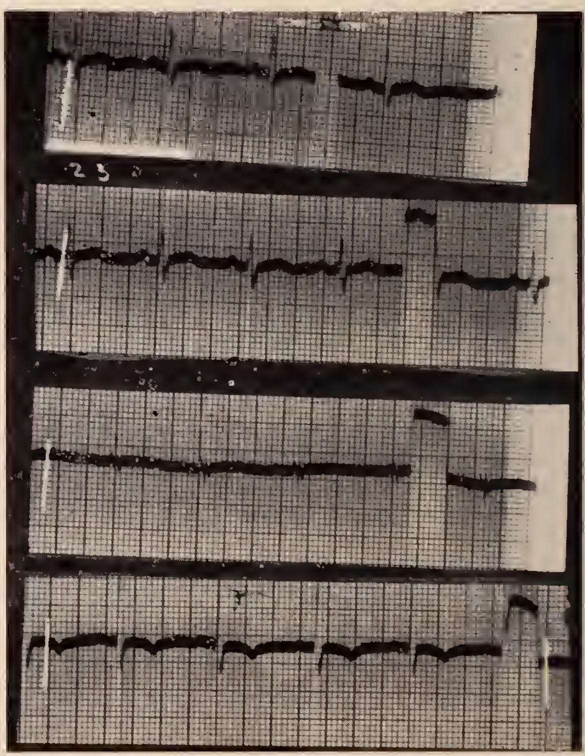

Fig. 10.—Diphastic T_1, T_4 Inverted.

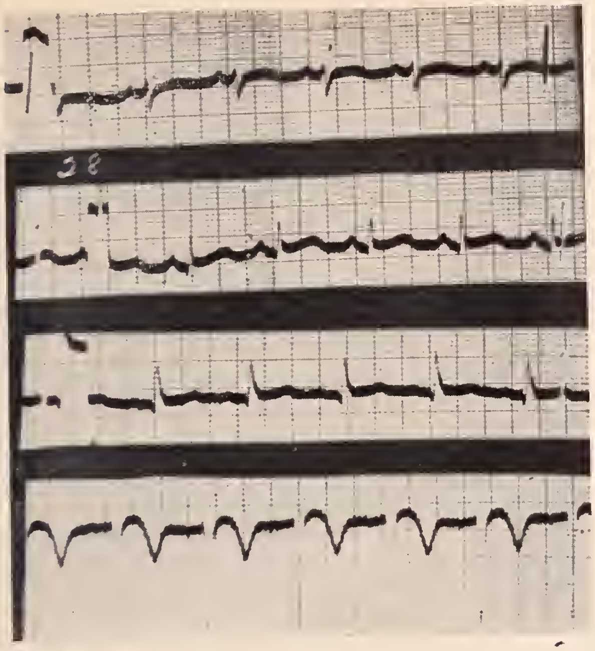

Fig. 11.—Absent R_4, T_4 Deeply Inverted.

limited and requires interpretation in the light of other findings and the overall clinical picture. T wave abnormalities are probably of greater diagnostic importance. Particularly in the age group under consideration, in whom arteriosclerotic disease of the coronary arteries is relatively infrequent, T wave changes may be of great significance. A possible explanation for the T wave abnormalities observed in rheumatic fever is supplied by the frequency with which changes in the coronary arteries have been noted in those of our patients who died during the course of rheumatic fever. In every such case studied at autopsy, coronary angitis was an outstanding pathological finding. Two patients died of thrombosis of major coronary vessels previously damaged by rheumatic arteritis. The almost universal involvement of the coronary vessels in rheumatic fever certainly provides ample explanation for the T wave changes which are so reminiscent of those noted in other forms of coronary artery disease. Damage to more than one part of the coronary circulation seems indicated by the changes observed.

From the standpoint of determination of rheumatic activity, however, the importance of T wave alterations must be evaluated in conjunction with other clinical and laboratory findings. All other electrocardiographic changes observed are in no way peculiar to rheumatic fever, and should be evaluated with this in view.

SUMMARY

1. The electrocardiographic abnormalities observed in 6,000 cases of rheumatic fever are noted.
2. The significance of certain arrhythmias is indicated. It is suggested that heightened nodal irritability exists in certain cases of rheumatic fever.
3. The significance of alterations in the P waves, particularly when changing is observed.
4. The limitation of the diagnostic and prognostic importance of prolongation of the P-R interval is noted. Both prolonged and changing P-R intervals were observed in apparently inactive rheumatic fever patients.
5. The possible rheumatic etiology of certain instances of bundle branch block and the syndrome of short P-R interval with wide QRS complex in certain instances is observed.
6. Deviation of the ST junction, when fixed and un-

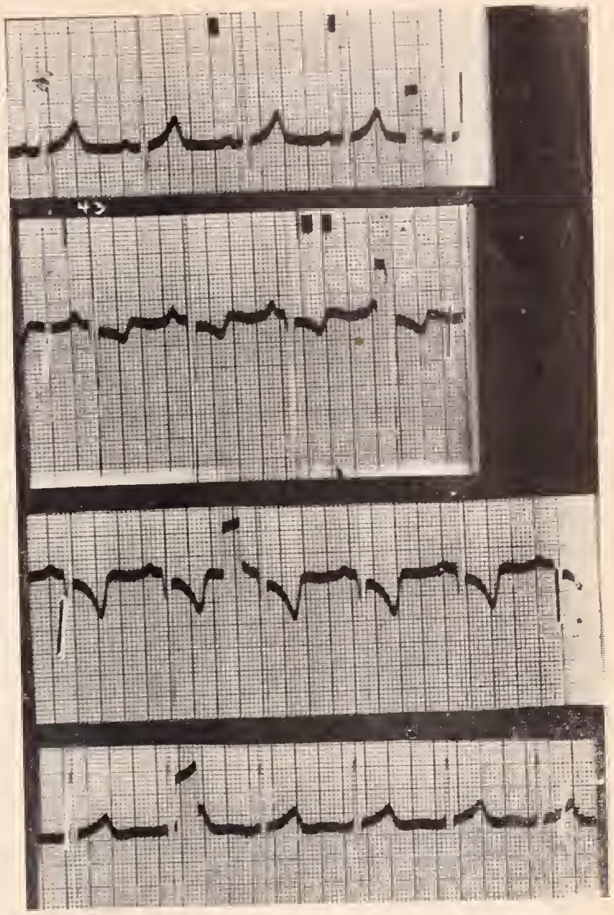

Fig. 12—ST_2 and ST_3 Depressed, T_2 and T_3 Inverted.

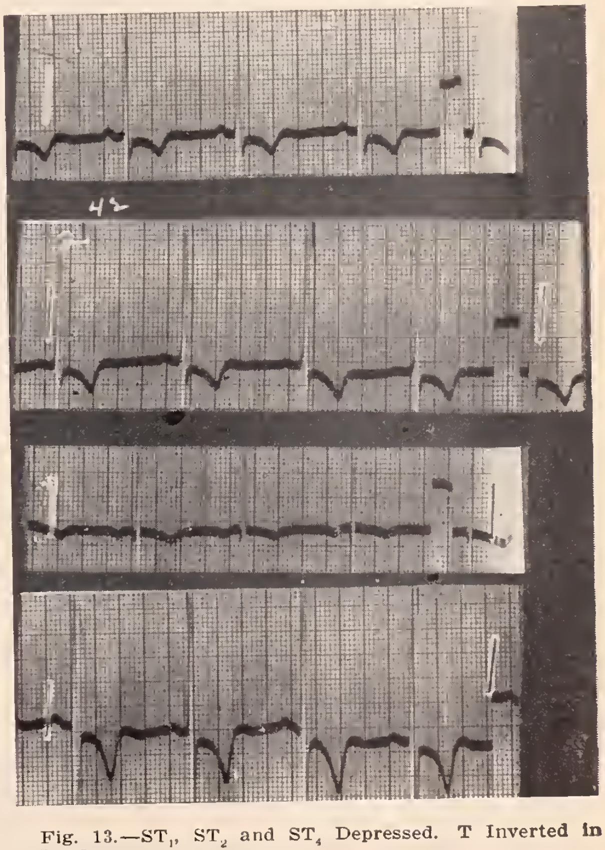

Fig. 13.—ST_1, ST_2 and ST_4 Depressed. T Inverted in All Leads.

associated with other abnormalities was not observed to a greater degree than in normal individuals. It is believed to be without significance.

7. Frequent changes in T waves were observed in this group. The limitation of the value of T wave changes in the estimation of rheumatic activity is noted. An explanation for these changes based on changes in the coronary circulation is suggested.

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TULAREMIC PNEUMONIA*

REPORT OF A FATAL CASE

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TULAREMIA (deer fly fever) is an infectious disease caused by Bacterium tularense (Pasteurella tularensis), occurring in humans and over twenty kinds of wild life, especially in wild rabbits and hares. It was first discovered by McCoy[1] in 1910. The original investigative work was conducted in Tulare County, California, hence the name tularemia.

Man becomes infected by contact of his unprotected, even apparently unbroken skin or mucus membranes, with raw tissue of infected animals, and by bites of blood sucking ticks and flies which have fed on infected animals.[2] Mosquitoes have been reported capable of transmitting the disease to man.[3] Whether or not humans may contract the disease via the respiratory tract is an unsettled question, the proponents and opponents both having evidence worthy of being weighed.[4]

Tularemia has been considered to be almost exclusively of the following four types: 1. Ulceroglandular; 2. Oculoglandular; 3. Glandular; and 4. Typhoidal, or cryptogenic.

While the pulmonary form has been known it, until recently, was considered to be exceedingly rare.

TULAREMIC PNEUMONIA

The marked increase in the number of cases of tularemic pneumonia being reported in the last several years indicates among other things the systemic nature of tularemic infections. Blackford and Casey,[5] in 1941, were able to find but 150 reported cases of tularemic pneumonia in the American literature. Stuart and Pullen,[4] in August, 1945, increased this figure to 268. This figure includes cases which seem almost purely pneumonia and those which have pneumonia as part of a more systemic or generalized tularemia. They found tularemic pneumonia in 9.3 per cent of a series of 225 cases of tularemia. The cases of relatively pure pneumonia may be difficult to separate accurately from those having pneumonia as a part of a cryptogenic tularemia. The relatively pure cases of tularemic pneumonia still are to be considered rare. It is felt that the case being reported is such a case. This article with a case report is submitted for various reasons: tularemic pneumonia is still somewhat of a curiosity; tularemic pneumonias still have a high mortality; streptomycin gives encouraging promise of being the most effective therapeutic agent yet employed; and, unless this condition is kept in mind and included in the differential diagnosis in pneumonic conditions, these cases will be incorrectly diagnosed and incorrectly treated, a fatal issue likely resulting.

The first published report of pleuropulmonary tularemia was probably that of Verbrycke[6] in 1924. Sante[7] described the roentgenographic findings of pleuropulmonary tularemia in 1931. The non-typhoidal cases usually present early hilar adenopathy with subsequent retrograde extension of the involvement through lymphatic channels to the lung parenchyma or even the pleura. The typhoidal cases usually present primary involvement of the lung parenchyma. Lung abscess, pneumothorax, pleural effusion, and residual fibrosis have been reported.

PATHOLOGY

Gross and microscopic features were described in detail by Blackford and Casey.[5] The most frequent finding is a lobular pneumonia involving any or all lobes. Both red and gray hepatization are frequently found.

DIAGNOSIS

Moss and Weilbaecher,[8] in 1941, reviewed the recent advances in the diagnosis of tularemia.

An occupational history may expose a clue to the diagnosis. A history of the patient's having been exposed to ticks, deer flies, or having been on a hunting or camping trip may be illuminating.

The symptoms vary greatly in severity. Frequently they are so mild that, without the chest film pneumonia would not be recognized. Especially in those cases seeming to develop as a primary pneumonia, suggesting that the organisms may have been inhaled, the onset may be sudden and the course fulminating. Cough, fever, chill, diaphoresis, pleurisy, sputum, dyspnea, and prostration are common. Cyanosis, delirium, stupor, and coma may develop in severe cases.

The fever is usually irregular and spiking, the pulse relatively slow.

In general, the physical findings are usually those to be expected in atypical pneumonia, but occasionally may be those of lobar pneumonia. The physical findings may be normal, while the chest film discloses the presence of pneumonia.

Special Studies.—The x-ray findings were described above. Sputum studies have, at times, yielded the organism. Blood cultures, though not frequently fruitful, should be taken. Agglutination tests, especially if there is a rising titre, are more valuable but cannot be relied upon until the second week of the illness. In some cases, more especially the fulminating ones, the test may be delayed or fail to develop.

Animal inoculation with properly collected material from the lung, lymph nodes, blood and sputum gives a high percentage of accurate results. Tissues from the spleen, liver, lymph nodes, and lung taken at the time of autopsy may be injected into susceptible animals for diagnostic purposes.

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* From the Medical Service, Letterman General Hospital, San Francisco.

Other laboratory studies contribute little to the diagnosis.

COURSE

Tularemic pneumonia may be mild or severe, insidious or fulminating. It is at best alarming and if bilateral has a grave prognosis. Stuart and Pullen[4] report a mortality of 40 per cent in a series of 268 cases. The condition may last from a few days to several weeks. Complications should be diligently sought in cases lasting three or more weeks.

TREATMENT

Foshay[9] is of the opinion that specific immune serum, administered early, reduces the severity and duration of the disease.

Sulfonamides have been administered with doubtfully favorable results.

Penicillin seems equally ineffective.

Streptomycin is reported by Heilman[10] to hold encouraging promise of being an effective therapeutic agent.

Unless streptomycin proves to be an effective agent, the treatment of uncomplicated tularemia seems still largely limited to symptomatic and supportive care.

REPORT OF CASE

(W. B. McG.), a 37-year-old, white male soldier was admitted to Letterman General Hospital May 29, 1945, with a transfer diagnosis from a local dispensary of "Acute Nasopharyngitis".

On May 25 he developed progressive sore throat, headache, general malaise, pain in his left chest, and chilliness.

The admission physical examination revealed a flushed face, injected sclerae and naso-oropharynx, limited excursion of the left thoracic cage, signs of consolidation of the left upper lobe, tachycardia (120), and a fever of 104 degrees.

The x-ray chest film taken on the date of admission revealed a diffuse area of increased density involving the greater portion of the left upper lobe considered to be due to a pneumonic consolidation.

A series of four hematologic studies from May 29 to June 4 revealed the R.B.C. to range from 3.6 to 4.7 million; the W.B.C. from 4,650 to 7,050, of which 65 to 82 per cent were neutrophils; and the hemoglobin from 10.5 to 14.0 grams. Toxic granulation appeared in the neutrophils on June 4.

A series of urinalyses revealed a specific gravity of about 1.020, 1 to 2 plus protein, and a few coarse and fine granular casts.

The sputum showed predominant Strep. viridans, and no Neufeld typing, direct or on culture.

The blood culture, blood Kahn, and blood smear for malaria were normal.

Study for cold agglutinins and blood chlorides were normal.

Blood drawn on admission was forwarded to the Hooper Foundation, University of California, San Francisco, for virus studies. The result was non-contributory.

Treatment from time of admission consisted of oxygen therapy, sulfadiazine (for but the first day and without benefit), penicillin intramuscularly from 30 to 40 thousand units every three hours throughout his hospitalization, intravenous glucose, salt, amino acids, vitamins and fluids, anadynes and sedatives.

The course was progressively unfavorable. The pneumonia continued to spread. Death ensued June 4, 1945.

Clinical Diagnosis.—Pneumonia, primary, atypical, bilateral, severe, probably due to a virus.

Anatomic Diagnosis.*—Pneumonia, lobar, acute, upper and lower lobes of left lung and upper lobe of right lung, due to Pasteurella tularensis.

COMMENT

The diagnosis in this case is based on the following studies by the Hooper Foundation, University of California:

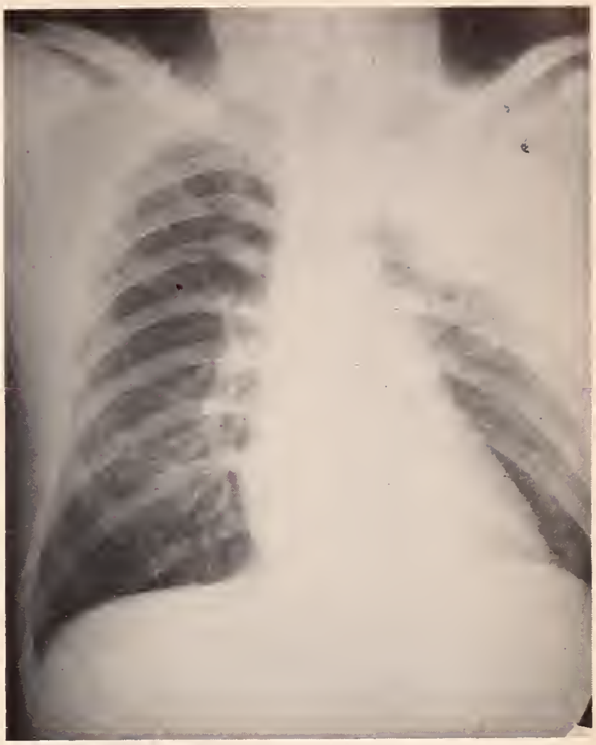

Fig. 1.—X-ray of the lungs taken May 29, 1945 (date of admission).

Material from the spleen and lungs, obtained postmortem, was inoculated into mice and guinea pigs. Focal necroses of the spleen and patchy pneumonic areas developed in both animals. Direct smears from the lungs of the mice revealed innumerable small gram negative coccobacillary bodies compatible with Pasteurella tularensis. P-tularensis was cultured in cystine agar from mice and guinea pigs. Heart blood from the patient postmortem completely agglutinated a known suspension of killed P-tularensis organisms in a titer of 1 to 2,000.

When it was determined this patient died of tularemic pneumonia, an attempt was made to supplement the history with the following result:

Immediately prior to the onset of his illness, the patient returned from a furlough, part of which was spent fishing and fox hunting on and near the Brazes River in Texas. A small tick, locally called "seed tick" and considered a harmless annoyance, was numerous in that part of Texas at that time. No evidence of ulcer indicating a bite was observed during hospitalization or at the postmortem examination. As far as could be determined, the soldier had not skinned any game. Whether he had handled or clubbed any was not learned. In this way he might inhale organisms with the dust or might offer entry through his skin.

This case could serve as evidence that tularemic pneumonia is at least sometimes contracted via the respiratory tract. The opponents, however, can contend that a substantial percentage of glandular tularemia is diagnosed in the absence of evidence of the victim having been bitten. These cases, they contend, quite certainly have been bitten in spite of the lack of local evidence.

SUMMARY

1. A brief description of tularemia, emphasizing the pneumonic form is outlined.
2. A fatal case of relatively pure tularemic pneumonia is reported in which the portal of entry is undetermined.

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* A thorough, gross, and microscopic autopsy was performed by Harold L. Stewart, Colonel, Medical Corps, Army of the United States; Henry D. Moon, Captain, Medical Corps, Army of the United States, and Harlan I. Firminger, Captain, Medical Corps, Army of the United States. To these officers the author is very grateful for their contribution to this case report. To the Hooper Foundation, University of California, the author likewise desires to give due and generous credit and to express his appreciation.

3. The profession is reminded that tularemic pneumonia may be misdiagnosed and mistreated as primary, atypical pneumonia unless it is seriously considered in the differential diagnosis.

4. The tularemic pneumonia rapidly spread in spite of the administration of 280,000 units of penicillin daily.

5. Steptomycin promises therapeutic efficacy against tularemia beyond that of any agent hitherto employed.

7850 Ivanhoe.

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POLIOMYELITIS*

REPORT OF A SECOND ATTACK

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SECOND attacks of poliomyelitis have been reported in several cases two years or more after the first attack and recurrences have been reported within three months or less. The definite diagnosis in the case described below seems to differ with some statements made concerning immunity to poliomyelitis after an attack of the disease.

Fischer and Stillerman[1] were able to collect 13 cases in 1938 which they considered authentic cases of second attacks. Nelson and Green[2] in 1943 added four more cases. Wyllie[3] in 1945 reported another case from Canada. Undoubtedly other cases have occurred.

Nelson and Green[2] state that the average interval between attacks in their series was five years, with the shortest interval two years. In no accepted cases of second attacks reported in the literature has there been less than a two year interval. They do point out, however, "that the absence of reinfection in reported cases during this two year period could be due entirely to chance." The fact that the second attack was more severe than the first is not uncommon. Some writers feel that this may depend upon whether the second attack is caused by a homologous or heterologous strain of the virus and whether the portal of entry was the same for both attacks. Howe and Bodian[6] showed that in Rhesus monkeys when animals were inoculated with a homologous strain of poliomyelitis virus in another part of the central nervous system that the animals developed typical symptoms of poliomyelitis.

Still[4] in 1930 proposed that the quiet period when patients do not develop poliomyelitis suggests an effective immunity for at least two years. Animal experimentation as well as pathological examination of human tissues would seem to question any specific period of immunity in an individual.

REPORT OF CASE

History of First Attack.—W. C. F., male, age 30 years, had his onset August 25, 1943. He complained of pain in the back and neck with marked nausea and vomiting when the author first saw him on August 26th. By August 28th, when he was admitted to the Isolation Ward, he had marked weakness of extension and flexion of the left arm and the right leg. He was was unable to void and did not regain control of his bladder for five days. Vomiting also persisted. Spinal puncture revealed 27 white blood cells per cu. mm. with 2 polymorphonuclears, 25 lymphocytes and 51 gms. total protein per 100 c.c. His admission temperature was 100.6 F. which became normal on the seventh day after onset and remained normal during this attack. He was given hot packs to arms, legs, back and neck. His left arm had a little function in the deltoid muscles and some in the flexor and extensor muscles when he was dismissed from the hospital on September 13, 1943. The right tibialis anterior remained weak and the right Kernig was positive. His back muscles were also in spasm. He continued with his hot packs at home in addition to other physiotherapy and by September, 1943, was able to resume his duties as a radio operator with the Police Department. At the end of six months he had so completely recovered that no weakness could be found in any of the affected muscles and he resumed his duties as a patrolman and attended a life-saving course given by the Red Cross.

* * *

History of Second Attack. — About ten days before W. C. F.'s last illness, a relative living in the same household developed pain lasting about two days in the back and in the hamstring muscles of one leg. He had a maximum temperature of 100 degrees F. His recovery was uneventful and he returned to work in about five days. At this particular time there were several such cases seen in the community.

On November 7, 1944, W. C. F. had a slight fever and felt dizzy. By the next morning he noticed a weakness in both arms and was nauseated and vomiting. No weakness was found in either leg at this time. On November 12, 1944, he was admitted to the Isolation Ward with a temperature of 100.4 and both arms and legs had become flaccid. His spinal puncture showed 120 w.b.c. all lymphocytes. By September 14th he began to have difficulty swallowing although his vomiting had stopped. His temperature gradually decreased to 99.0 F. Respiratory paralysis became marked and he expired in the respirator on November 14, 1944, one week after onset.

COMMENT

On autopsy the right and left occipital lobes showed a few sub-arachnoidal hemorrhages about 0.5 to 1 cm. in diameter. Pial vessels were markedly congested. Microscopic examination showed complete loss of motor cells from the anterior horn of the cord. At some levels, however, absence of motor cells in a given area of the gray matter was not accompanied by acute inflammatory reaction. This may have been the result of the first infection. Typical lesions were found also in the brain stem. Two monkeys were inoculated with a fresh specimen from the brain in the laboratory of Dr. Harold K. Faber, Stanford Medical School, and one developed a typical paralysis of poliomyelitis after ten days with typical lesions in the cord.

City Hall, San Jose.

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HYPERTENSION — SOME RECENT ADVANCES IN OUR KNOWLEDGE*

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It is now over twelve years since Goldblatt and his associates[1] demonstrated that persistent hypertension could be produced in dogs by partial constriction of the renal arteries. This historic observation has been confirmed repeatedly on a variety of laboratory animals, and stimulated a vast body of research upon the nature of experimental and human hypertension. Both the benign and malignant varieties have been reproduced by inducing renal ischemia, and the characteristic necrotic lesions of malignant nephrosclerosis have been duplicated. Goldblatt made the interesting observation that the hypertension which occasionally develops after making one kidney ischemic can be abolished by removing that kidney.[2] Although the number of instances of human hypertension which seem to be due to unilateral renal disease is very small,[3] the cure of such cases by nephrectomy is a direct outcome of the knowledge gained from Goldblatt's observations.

RENIN AND OTHER STUDIES

Because they are so well known, the studies on renin will be summarized briefly. In 1898, Tigerstedt and Bergmann[4] showed that saline extracts of the kidneys of rabbits produced a sustained rise in blood pressure when injected into other rabbits, and they named the active principle *renin.* Harrison, Blalock and Mason,[5] as well as Friedman and myself,[6] demonstrated in 1936 that more pressor substance could be extracted from ischemic kidneys than from normal kidneys. It remained for Braun-Menendez in South America[7] and Page[8] in this country, together with their respective coworkers, to demonstrate that renin, a proteolytic enzyme, was without pressor activity until it acts on one of the blood globulins (a_2 globulin) to produce a polypeptide termed *hypertensin* by the South Americans and *angiotonin* by Page and his group. The latter claimed to have isolated this substance in pure crystalline form.[8] An increase in circulating renin and angiotonin has been reported clinically in acute glomerulonephritis and in eclampsia.[9]

There is also an enzyme in the blood called *hypertensinase* which inactivates hypertensin.[10] We have found unusually high concentration of this enzyme in the red blood cells.[11] The amount of hypertensinase in the blood is decreased by nephrectomy. It has been shown that there are both pressor and depressor substances operating in the normal kidney. Depressor extracts have been isolated from normal kidneys by a number of investigators.

Bing and Zucker[12] described another renal pressor mechanism which they demonstrated to be produced in the ischemic kidney by decarboxylation of certain amino acids.

There is no doubt that both the renin and the pressor amine mechanisms are humoral ones. A neurogenic origin for the elevation of blood pressure in experimental renal ischemia has been excluded in a number of ways. For example, it has been found that renal denervation[13] or sympathectomy[14] does not prevent or relieve the hypertension produced in dogs by renal ischemia. Blalock and Levy[15] further demonstrated that this type of hypertension develops even when the ischemic kidney has been transplanted into the neck of dogs. Goldblatt himself came to the conclusion that the renal pressor mechanism was a humoral one, and in further support for his belief he showed that if the renal veins were obstructed at the same time as the arteries were constricted, no elevation in blood pressure occurred.[16]

Contrary to Goldblatt's hypothesis that the hypertension which results from constriction of the renal arteries is due to renal ischemia, Page suggests that intrarenal reduction of pulse pressure may be the causative factor.[17] He bases this view on the fact that renal hypertension may occur in the absence of renal ischemia; also that the pressure distal to the clamp in Goldblatt dogs is sometimes normal,[18] and the renal blood flow is not always reduced.[19] The production of persistent hypertension in dogs by compression of the renal parenchyma is thought by Page to be due to diminishing the pulsation in the renal vessels, but as Goldblatt has suggested,[20] this occurs by compressing the vessels and causing renal ischemia.

If reduced pulse pressure is an adequate explanation for the genesis of renal hypertension, it is difficult to explain why patients with aortic stenosis and low pulse pressures should not all have hypertension. Sidney Leo, while working in this laboratory, examined the records of all patients in the Los Angeles General Hospital with aortic stenosis, and found no instance of hypertension even when the pulse pressure was as low as 10 to 20 millimeters of mercury.[21]

CLINICAL OBSERVATIONS

Clinically, the most important physiologic alteration in hypertension is the increased peripheral arteriolar resistence.[22] However, the exciting cause of this vascular disturbance has not been established. The large incidence of renal arteriosclerosis observed in hypertensive subjects at necropsy gave further support to Goldblatt's experimental evidence that renal ischemia resulted in hypertension, and suggested that renal ischemia might also be the primary disturbance in human hypertension.[23] There can be no doubt that marked narrowing of the renal arteries produces hypertension in man and a few case reports with convincing evidence in favor of this have been presented. We have recently observed such a case.[24]

REPORT OF CASE

History.—A woman, aged 53, was admitted to the Cedars of Lebanon Hospital on September 1, 1940. On the previous evening severe epigastric pain suddenly developed and she became faint. Within the next few minutes she became nauseated and dyspneic. Because of the persistence of these symptoms she was admitted to the hospital. She was known to have had rheumatic heart disease of many years' standing. Her blood pressure taken on several occasions before the present episode was found to be normal.

Examination.—On admission to the hospital the radial pulse was 120 a minute, with evidence of auricular fibrillation. There was no cardiac enlargement and the blood pressure was 110 systolic and 95 diastolic.

Course.—The day after admission her blood pressure was 130 systolic and 100 diastolic and she was given quinidine, which converted the auricular fibrillation to normal rhythm. On the tenth day the blood pressure was 170 systolic and 110 diastolic and on the twelfth day 200 and 120. The urinary secretion, which had been diminishing progressively, almost ceased. On the eighteenth day, the blood pressure was 190 systolic and 100 diastolic and the specific gravity of the urine had fallen to 1.008. Measurable quantities of albumin were present in the urine, and in the sediment there were numerous leukocytes, epithelial cells and a moderate number of erythrocytes but no casts. The nonprotein nitrogen rose to 72 mg. per hundred cubic centimeters on the seventh day after admission to 148 mg. on the day before death. There was increasing stupor, and death occurred on September 21, three weeks after admission.

A clinical diagnosis of occlusion of both renal arteries was made. The most probable cause was considered to be embolism, although the possibility of a dissecting aneurysm of the aorta involving the orifices of both renal arteries was also considered.

Postmortem Examination.—At the autopsy unilateral renal infarction was found due to thrombo-embolism of the aorta at the origin of both renal arteries. A perfusate of the one infarcted kidney contained large quantities of renin.

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* Read before the Section on General Medicine, at the Seventy-fourth Annual Session of the California Medical Association, Los Angeles, May 6-7, 1945.

COMMENT

The problem still remains as to whether the renal pressor mechanism is primarily responsible for human hyptertension whether or not renal ischemia is present. Several years ago Pickering and I gave single intravenous injections of renin to rabbits. At the height of the pressor response the animals were bled and the blood extracted. The extract contained large quantities of renin.[25] However, when the blood of a patient with essential hypertension or that of an animal with Goldblatt hypertension was extracted by the same method, no renin could be demonstrated in the extract.[26] Furthermore, extensive transfusions of blood from hypertensive patients failed to cause any elevation of blood pressure in recipients.[27] More recently, Haynes and Dexter,[9] using methods developed by the Buenos Aires school, were unable to demonstrate any circulating pressor substance in patients with so-called essential hypertension. They found an increased quantity of renin only during the ascending blood pressure in eclampsia and acute glomerulonephritis. However, when the blood pressure was persistently elevated they were unable to detect hypertensin in the peripheral blood.

Evidence has been presented by a variety of investigators that the renal blood flow is not always reduced in essential hypertension. William Dock,[28] for example, has shown by perfusing kidneys of hypertensives, obtained at autopsy, with kerosene, that there does not seem to be any obstruction of flow through the renal vessels. Castleman, Smithwick and Talbott[29] studied the pathology of the kidney in various stages of human hyptertension by obtaining renal biopsies during sympathectomy. They could find no evidence of renal arteriosclerosis in the early stages of essential hypertension. However, in the later stages, renal arteriosclerosis was a constant finding, and proportional to the severity of the vascular lesions in the kidney was a decrease in renal blood flow. On the other hand, Moritz and Oldt[23] found changes in the renal vessels in a large number of patients with hypertension.

It would seem, therefore, that the renal pressor mechanism has not been completely proved as the cause of all cases of essential hypertension. Attention has increasingly been directed toward a neurogenic, or vasomotor, genesis of essential hypertension. Evidence in favor of this theory is not conclusive but suggests that increased activity of the vasomotor center has some etiologic importance. The therapeutic effects of sympathectomy can be considered as evidence in favor of this hypothesis.[30] Recently, Medoff and Bongiovanni[31] produced hypertension in rats by audiogenic stimulation.

THERAPY OF ESSENTIAL HYPERTENSION

As clinicians, we are interested in the therapy of essential hypertension. As previously mentioned, antipressor activity has been demonstrated in extracts of normal kidneys. The administration of such depressor extracts to hypertensive subjects could be expected to be therapeutically useful.

Harrison and his coworkers,[32] and Page and his group[33] prepared such extracts which, when administered to hypertensive patients and animals, caused a significant reduction in blood pressure. This observation was regarded as one of great significance in the treatment of hypertension, and the use of these extracts was widely investigated. All those who used kidney extracts noted varying degrees of local and systemic reactions. The possibility presented itself that the therapeutic effect might be due to these nonspecific reactions. Schroeder and his group at the Rockefeller Institute[34] observed that tyrosinase preparations extracted from mushrooms had a beneficial effect when administered to hyptertensive rats and to patients. Tyrosinase is an enzyme which destroys certain pressor amines including renin. We observed that heat-inactivated tyrosinase preparations can produce significant lowering of blood pressure and remission of other symptoms of arterial hypertension in man. Such effects as have been observed are as marked as those which have been reported by others following injections of active tyrosinase preparations, and therefore show the effects upon the symptoms of arterial hypertension to be unrelated to the enzyme content of the preparations.

Roy Scott observed beneficial results following the intravenous injection of typhoid vaccine.[36] Clara Margoles and myself treated several hypertensive patients with a casein digest prepared by Dr. Gordon Alles.[37] We found that these extracts caused a lowering of blood pressure, decrease in cardiac size, improvement in the cardiogram especially a reversal of the inverted T wave in Lead I, and improvement in the eye grounds. It was concluded that the therapeutic activity of kidney extracts could be explained as being due to a non-specific protein or proteose reaction. These observations do not disprove the existence of a specific substance in the kidney which may be therapeutically useful in hypertension, but such a substance has not yet been convincingly demonstrated because the same effects can be produced by non-specific agents.

Although there was marked improvement in patients while they were receiving the extract, when treatment was stopped the blood pressure gradually returned to previously high levels and the disease continued. It would appear doubtful to me whether the pain and discomfort the patient suffers is justified by the temporary improvement, and we have discontinued using such non-specific extracts for the treatment of hypertension.

Thiocyanate, as is well known, has been widely employed for the treatment of hypertension. In spite of the knowledge obtained by Barker that the blood concentration of thiocyanate must be carefully watched and maintained at a proper level,[38] a few untoward reactions and even fatalities have resulted. The mechanism of action of this drug is not known, although Dalton and Nuzum[39] demonstrated that the pressor effect of angiotonin was reduced in animals which had previously received thiocyanate. We found in perfusion experiments that thiocyanate does not diminish the liberation of renin in an isolated ischemic kidney.[40] Clinically, a relatively small percentage of patients have received benefit from this therapy. Some have ascribed the hypotensive effect of thiocyanate to its sedative action.[41]

Ben Friedman and his coworkers observed that a variety of quinones have marked hypotensive effect in experimentally produced hypertension.[42] This has been confirmed by several investigators. The quinones are relatively toxic and to our knowledge have not yet been used in human cases. It is possible that a further study may prove this group of drugs to be of great value in hypertension.

Kempner of Duke University[43] observed that the elimination of protein intake by a diet consisting essentially of rice had marked therapeutic effects in certain patients with severe hypertension. Our experience with this diet has not been too successful, mainly because it is not palatable and patients find it difficult to continue this régimé for a prolonged period of time. The mechanism by which such a diet is useful in hypertensive patients without an elevated non-protein nitrogen is obscure; that it can lower an elevated N.P.N. is understandable. It would seem that modifications of Kempner's diet are worthy of further trial. Low sodium diets[44] have also been found to be of benefit in hypertension but conclusions cannot be drawn from the small number of cases treated in this manner.

Vitamin A[45] and vitamin K[46] have also been recommended for the treatment of hypertension but their therapeutic value has not been generally confirmed at yet.

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HUMAN PLASMA—SURPLUS DRIED*

ITS DISTRIBUTION IN CALIFORNIA

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The American Red Cross has announced that approximately one and one-quarter million units of surplus dried human plasma will be made available for civilian use. This plasma was originally collected through the American Red Cross blood donor program, prepared in dried form and shipped to the various battle areas throughout the world. With the termination of hostilities the large stores which accumulated were no longer needed and are now being returned to the United States for civilian use.

The American Red Cross has been authorized to distribute the plasma to the various state health departments who have been asked to assume the responsibility for the distribution of plasma within their respective states.

The general features of the American Red Cross Plan are as follows:

1. An initial allocation, based on the number of licensed

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* From the office of the Department of Public Health, State of California.

physicians and number of active hospital beds in the state will be made to each state health department.

2. The state health department will prepare a plan for the distribution of plasma within the state. Upon approval of the plan by the American Red Cross the initial allotment will be made available.

3. Subsequent allocations of plasma will be made available by the American Red Cross only upon request from the state health department.

4. The plasma is to be supplied and distributed free of charge. No charge will be made to any patient for plasma received.

5. The state health department will report at monthly intervals the amount of plasma received and distributed within the state.

The following plan for distribution of plasma in California, adopted by the State Department of Public Health, has been approved by the American Red Cross, the California Medical Association, and the Association of California Hospitals:

1. Distribution to areas where there is a full time local health service will be made through the local health departments. Initial allocations will be made to each local health department and distributed by one of the following procedures.

a. The initial allotments will be sent directly to the local health department for distribution by them.

b. The local health officer will supply the Division of Laboratories of the State Health Department with a list of hospitals in the local health jurisdiction indicating the amount allocated to each. The State Health Department will then ship the initial allotments to the hospitals indicated.

2. Distribution in areas where there is no full time health service will be through the county health officer whenever such arrangements can be made. If the health officer does not elect to act as the distributing agency for his county a medical agency in the county will be selected or the State Health Department will distribute plasma directly to the hospitals and physicians on request. The initial allocation will be issued only to counties where the county health officer or an approved agency acts as the distributing agent.

3. In order to avoid the piling up of plasma in offices or institutions where plasma may not be needed it is recommended that the local health departments make initial allocations to hospitals only, reserving a supply in the health department for any requests that may be made. The plan contemplates that doctors on hospital staffs could draw from the hospital supply for any plasma needed for outside cases. If the doctor is not affiliated with any hospital he should make application for plasma directly to the local health department or designated agency. If no agency has been approved for a county, applications for plasma should be made directly to the Division of Laboratories, California State Department of Public Health, Berkeley, California.

4. The supply of plasma in local health departments or approved agencies may be replenished from time to time upon request to the Division of Laboratories. Physicians and hospitals should direct their requests for plasma to their local health departments or to the local distributing agency.

5. The local health department or agency will report to the Division of Laboratories at monthly intervals the amount of plasma received and distributed. The State Health Department will furnish reporting forms and record cards in order to standardize the reports and records and to reduce the amount of clerical work to a minimum.

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The plasma is prepared in dried form and packaged in 250 cc. and 500 cc. sizes. 500 cc. of plasma is regarded as one unit. Each package contains, in addition to the bottle of plasma, a bottle of sterile diluent sufficient to restore the plasma to its original volume and complete equipment for the rehydration and administration of the plasma.

It is the intent of this plan to make the plasma readily available, without cost, wherever and whenever it is needed in the state.

Plasma is now being distributed as rapidly as it becomes available from the American Red Cross.* The initial allocations are being delivered county by county. Each initial allocation will be accompanied by announcements through the local newspapers as the plasma becomes available in each area. It is hoped that complete distribution of the initial allocations can be made within two months.

While it is estimated that the available plasma will meet the needs of the civilian population for approximately two years, it should be borne in mind that this is only a small part of need for blood for transfusion purposes. Local blood banks must be relied upon for whole blood for transfusions.

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BLAST INJURY OF THE SPINE

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CONCUSSION of the back resulting from an exploding shell or bomb is a rare but interesting injury. Some data on fifteen soldiers with this injury are listed. It would have been interesting to follow these patients for a period of months or years, but because of the necessities of war I have seen them only for three to eight days. X-rays revealed no fractures in any of these patients.

The history of injury was practically identical in each case. The nearby explosive lifted the soldier out of his original position on the ground and he was deposited several feet away. They could not tell exactly how they landed but none thought that they landed with great force. It was their impression that the blast of air injured their backs rather than the resulting fall. Physical examination revealed little. There was tenderness of a diffuse nature usually in the lumbar area, usually bilateral. Motion of the involved area of spine was somewhat limited in all directions by pain. In only one case was there associated hematuria.

The most interesting feature of this group is their prognosis. It will be noted from Table 1 that lack of improvement was correlated with a history of previous chronic backache. All patients had simple symptomatic treatment consisting of analgesics, bed rest and baking and light massage. In only one case where a previous history of chronic back pain was present did any diminution of pain occur. On the other hand, improvement took place in every patient with no previous history of back pain.

SUMMARY

A series of fifteen patients who were injured by the concussion of a nearby explosive is reported. A definite correlation existed between the history of previous back pain and lack of improvement of symptoms.

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* A mimeographed circular (Number 80428) has been issued by the Medical Director, American National Red Cross, Washington, D. C., under date of Feb. 11, 1946, with caption, "Normal Human Dried Blood Plasma, Army-Navy Surplus." It gives information concerning clinical use, and will be supplied on request by the Division of Laboratories, California State Department of Health, Berkeley 4, California.

TABLE 1.—*Summary Concerning Fifteen Patients. Showing Correlation Between History of Previous Back Pain and Lack of Improvement of Symptoms*

Reference Number	Names	Age	Distance from Explosion	Previous Chronic Backache	Response to Rest and Physiotherapy
1.	R. L.	32	10 yds.	None	Improving after 3 days
2.	S. K.	32	5 ft.	Yes, for past 8 years	No improvement after 5 days
3.	M. V.	27	10 ft.	Yes	Very slight improvement after 1 week
4.	B. A.	28	3 ft.	None	Improving after 4 days
5.	J. B.	26	5 ft.	None	Improving after 6 days
6.	P. P.	35	10 yds.	Yes	No improvement after 5 days
7.	J. C.	40	6 ft.	None	Some improvement after 6 days
8.	C. P.	20	20 yds.	Yes	No relief after 5 days
9.	L. W.	23	10 yds.	Yes	No relief after 3 days
10.	S. C.	22	5 yds.	None	Improving after 4 days
11.	D. C.	30	5 yds.	Yes, (minor)	No relief after 8 days
12.	I. J.	27	10 yds.	None	Improving after 4 days
13.	F. H.	32	5 yds.	Yes	No relief after 3 days
14.	H. D.	20	8 ft.	Yes	No relief after 5 days
15.	R. D.	26	3 ft.	Yes	No relief after 5 days

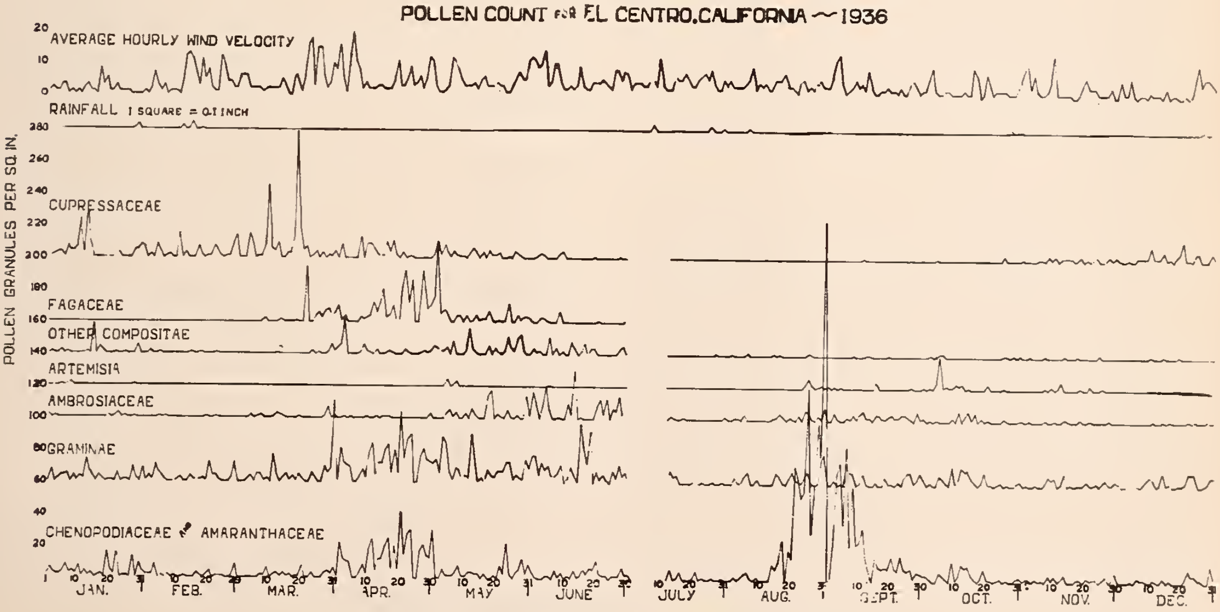
POLLINOSIS IN IMPERIAL COUNTY, CALIFORNIA, AND YUMA, ARIZONA

The tabular information and the graph appearing below are pertinent and supplementary to the article "Pollinosis in Imperial County, California, and Yuma, Arizona," by George F. Harsh, M.D., of San Diego, which appeared on page 245 of the April issue. They were inadvertently omitted from the issue in which the article was printed.

Pertinent Data on Plants of Importance in Pollinosis in Imperial County, California, and Yuma, Arizona

	Pollinating dates (months of year)	Pollen production	Size of pollen (microns)	Percentage of patients reacting		Plant abundance		Importance rating (Imperial County)
				1+	2-4+	Imperial county	Yuma area	
Galleta grass	2- 4	25	32	20	27	2	5	5
Bermuda grass	1-12	45	25	18	42	9	9	250
Knot grass*	6- 8	4	32	20	25	1–	2	
Honey mesquite*	4- 6	2	29	33	18	2	4	
Pecan tree*	5	++++	42	14	14	1–	5	
Careless weed	4- 9	150	29	21	24	4	5	70
Sowbane	2- 5	13	21	27	27	3	3	10
Shad scale	6- 9	60	25	24	30	4	3	40
Quail brush	8- 9	75	18	18	18	8	9	120
Cattle spinach	9	50	29	15	21	2	3	10
Desert holly	1- 4	35	25	30	10	1	0	5
Russian thistle	6- 9	30	25	18	30	5	3	30
Iodine bush	9-10	+++	18	36	24	2	1	10
Ink bush	8-10	20	25	27	21	6	2	20
Burrobush	2- 3	+++	21	19	11	2	1	10
Desert ragweed	3- 6	35	18	15	15	7	4	70

*Important only at Yuma.



Graph of daily pollen counts at El Centro, California.

THE INDUSTRIAL PHYSICIAN IN THE COMMUNITY HEALTH PROGRAM*

A. V. Nasatir, M. D.
Los Angeles

INDUSTRIAL medicine is an outgrowth of the broader science of medicine as a whole. Its evolution reflects the attitudes and developmental pattern of its parent discipline. Let us examine the current trend of development as it relates to the public health.

Medical science has gone far and as it has advanced so has the general health of the population. The standards of diagnosis and treatment have never been higher than they are now. Tens of thousands of individual doctors in clinical practice treating millions of patients have collectively produced a cumulative effect on the public health. Mortality has been reduced because death has been deferred. Life expectancy has been increased because of better and earlier diagnosis, because of more extensive and exact knowledge of treatment, and because of a field of medical endeavor too prone to be discounted or disregarded by the spokesman for the achievements of modern medicine. I speak of public health practice, to which I shall refer later. With all credit to clinical medicine, in the final analysis its accomplishments have all been in the direction of diagnosis and treatment. They bespeak a philosophy based on treatment. The approach to health has been a therapeutic one. At its worst, this approach has stood for restoration of health; at its best, it has meant preservation of health. But the collective effect on health stemming from the treatment of many individuals must eventually arrive at a level beyond which it cannot go. While in the early days of medicine more people got sick than were cured, there will never be a time when more people will be cured than get sick. In between these two extremes there is a point where the therapeutic approach brings results according to the law of diminishing returns. There is a diminishing rate of accomplishment from a health point of view out of proportion to the knowledge, effort, and skill expended by care and treatment of individuals. Eventually an equilibrium is reached beyond which no further cumulative effect on public health is derived.

THE TREND TOWARD PREVENTION MEDICINE

The trend today is toward prevention of disease and illness; the philosophy is one of promotion of health. It is a departure from negative attitudes and patterns of thinking and involves positive and constructive action. It means the utilization of new techniques and new approaches. They are the techniques of public health, the approach to health through group and community organization.

It is where these instrumentalities have been used that medicine has been most effective in promoting health. (Everyone will agree that our greatest achievement has been in the reduction of infant and childhood mortality, and in the control of communicable disease.) However, experience has shown that unless these methods are directed in an organized manner towards large numbers of individuals, the effect in the general population will be inadequate to accomplish the desired health protection. For example, diphtheria is one of the infectious diseases for which there is available not only specific treatment, but also a specific test to determine presence of immunity, and a proven method for establishing such immunity. This information is known to all physicians, and nearly all doctors dealing with children utilize it. Consequently, large numbers of children are tested and immunized by practitioners every year. Nevertheless, the case incidence and mortality tend to rise as soon as the index of over-all immunity of the population begins to drop below a certain point. More specifically, if only half the children of school age are immunized, that is the group between 5 and 14, the prevalence of diphtheria is unaffected. But if 55 per cent to 60 per cent of this age group is immunized and in addition at least a third of the preschool population under 5 years, mortality and frequency drop sharply. What I am trying to point out is that the required level of group immunity and concurrent health protection can only be reached and maintained by organized and planned community action. It has therefore been necessary periodically to put on "drives" to stimulate more extensive activity in the medical profession as well as acceptance by the community. These "drives" would not be nearly so successful were it not for the fact that access to large groups under centralized supervision and control is made possible through the school system. The schools have been of inestimable value for the opportunity and advantages they have offered in control of childhood diseases. They are an outstanding example of the effectiveness and the accomplishments of preventive medicine in reducing the mortality and increasing life expectancy in a major population group.

HOW PREVENTIVE MEDICINE HAS MADE FOR INCREASE IN LIFE EXPECTANCY

The logical consequence of these and other efforts of public health and preventive medicine has been that more and more children have been reaching the age at which degenerative diseases of maturity occur. The gradually increasing incidence of these has become a public health problem. It is logical therefore that medical thought should conclude that the field of adult health must be the objective of future campaigns in the war against disease. That does not mean that the areas in which success has been achieved should be neglected. The battle line on the child health front will be held and new and greater gains will be made. But as in any campaign, while the conflict rages on one front it is necessary to establish new fronts in order that over-all victory may be gained. It is the new front of adult health which has been opened up. Reflection will reveal that adults are really the largest segment of the population, and the majority of adults are workers. Further reflection will disclose that the only circumstances in adult life comparable to the school life of childhood are those of work. Instead of school systems we have industries. Instead of schools we have work establishments, factories, plants, or whatever they may be. And to these places come daily the same groups of adults, within the same environment under the same supervision and control. The same elements, the same agencies used in promoting child health through the schools are available for promoting adult health through industry.

Substitute the hazards of work for the hazards of childhood and you have occupational injuries and occupational disease instead of the acute communicable diseases. Substitute the industrial physician for the school physician and you get health education for adults instead of health education of children. The comparison is an obvious and easy one. The only absence of similarity is in the organization of effort.

RECENT DEVELOPMENT OF INDUSTRIAL MEDICINE AS A SPECIALTY

You will recall that I began this discussion by stating that industrial medicine reflects the attitude and developmental pattern of general medicine. This becomes apparent in studying the development of medical practice in industry. I shall dispense with the details of that development. Suffice it to say that experience and research into causes of occupational disease have disclosed a number of well defined hazards to health which vary with environment and manner of occupations, and which have made it possible for the practitioner in industry to progress from the concept of treatment to one of prevention. But the development of industrial medicine as a distinctive specialty is a comparatively new one, and earliest attitudes still tend to prevail. As long as industrial doctors dealt only with trauma of work, they practiced industrial surgery. But just as accidents are not the only influence in over-all life and health of the individual, neither are they so in industry. Therefore, the industrial practitioner of today has to consider other factors of the job; the materials which the worker handles; the manner in which he works; the housekeeping and sanitation of the environment; the physical factors such as dusts, gases, vapors, illumination, ventilation,—in short, all the factors which may become hazards to the health of the worker. As the field of endeavor of the industrial doctor expands, his efforts and interests are no longer limited to treatment; and traumatic surgery joins other industrial health and medical services to form the more comprehensive specialty of industrial medicine, or more correctly, industrial health. The industrial physician in this concept is more than just a physician or surgeon. He is doctor, administrator, sanitarian, and the liaison between labor and management. He is the health officer of the plant and as such his functions are to protect the worker's health from hazards arising out of occupation. But he also has responsibility to management. He must see that employees' absence from work because of injury or sickness is reduced to a minimum, and that the health of the employee is such that he can work with maximum efficiency on the job.

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* Adapted from a paper delivered before the Section of Industrial Medicine and Surgery, of the Los Angeles County Medical Association, February 14, 1946.

From the Division of Industrial Hygiene, Los Angeles City Department of Health, Los Angeles, California.

TYPES OF SPECIALISTS IN INDUSTRIAL MEDICINE

It is well known that physicians associated with industry fall into three obvious categories—those working full time, those who work part time with definite hours in the plant, and those who work only on call. It needs no great mental effort to realize that only those working full time are in a position to provide a true industrial health service, in the sense implied heretofore. The part-time physician can only render the degree of service which his relationship with management permits. It depends on how well he sells the idea of health to the management as well as on his own concept of what health services are. As for the "on call physician," here is what Sappington says about him. He "usually serves in such a disjointed fashion that he tends to lose interest in the real health problems of the industrial establishments with which he may have contact. This type of service is entirely curative, and what may be called obsolete." Selby, in an article published in *Industrial Medicine* in 1938 is also quoted as follows: "The full-time group, as the name indicates, gives its whole attention to industrial practice, and always in one establishment. These are the only true industrial physicians, who, as a group, apply the principles of preventive medicine to the maintenance of employee health."

IN RECAPITULATION

Recapitulating then, only the large size plant can afford to employ full-time industrial physicians. Only full-time physicians, assuming they have the vision, skill, and initiative, are in a position to promote a comprehensive health service in industry. Nevertheless, part-time physicians in the smaller establishments of the large plant group can also perform limited preventive services. They are in a position to provide, in addition to emergency care, routine preplacement examinations, periodic and follow-up examinations, and the basis for a health education program utilizing the nurse who is usually also employed by the plant. The big weakness in the industrial health program is the lack of even a minimum health service for small plant industry. On the one hand these offer a field for constructive health work in industry, and on the other hand there is a group of physicians who are on call for industrial health work but who do not realize the complete fulfillment of their potential opportunities and capacities. There are a number of industrial medical offices scattered throughout the industrial area of the city. How many of the administrators of these emergency hospitals, as they are often designated, engage in anything but glorified finger wrapping? How many on-call, or even part-time physicians for that matter, have ever toured a plant or examined the conditions of work from which their patients come? Maybe I am stepping in where angels fear to tread, but my contention is that constructive industrial health service can be provided for small plants, by industrial medical practitioners who are not full time. There are many who are industrial physicians only by virtue of the fact that they treat, and fill out insurance forms for conjunctivitis, dermatitis, and injuries occurring at work. There are many others, especially younger men, who would be glad to spend a part of their time in industrial health work. The problem is how to get the small plant employer and the potential industrial physician together.

INDUSTRIAL HEALTH PROGRAM OF LOS ANGELES

You are aware that the industrial health program of Los Angeles has received national commendation. The program is one which was established as a result of the efforts of an industrial health advisory council formed in war time. This organization made up of representatives of industry, official agencies, and the medical, dental and nursing professions, was coördinated by Mr. Franklyn Cole of the local Chamber of Commerce. It stimulated and promoted interest in health in industry and has been responsible for considerable expansion and active participation in health activities by industrial management. But, except for sporadic and occasional requests by small industry for assistance from official agencies, establishment of basic services has been accomplished only in the larger size plants, and only in a fraction of these. Nevertheless it has been demonstrated that industry can be reached and coördinated for health, through an effective organization. On the other hand, how can physicians be induced to engage in a small plant health program? How can the services of those already so engaged be improved, how can new physicians from the younger general practitioners be recruited and indoctrinated in the principles and opportunities of industrial health?

I do not think the obstacles are insurmountable. I believe that the Los Angeles Chamber of Commerce has the machinery for localizing areas of small plants either on a basis of like industries or on a basis of physical or geographical proximity. I believe that representatives of such small plant groups can be sounded out on their willingness to participate in a group industrial health service. I believe that they can be organized so that an over-all picture of their industrial health problems can be formulated, based on the various types of occupation, the hazards involved, and the environmental studies needed.

On the other hand, I believe the Industrial Medicine Section of the County Medical Association should agree on what the policy of its organization will be in relation to an accepted definition of the objectives and scope of industrial health and medicine. With a clearly defined policy, members who are not full-time industrial physicians, should be able to submit an estimate of the extent to which they could expand their activities in the direction of industrial health practice. Those whose time was fully occupied with existing industrial commitments should consider the employment of younger medical men, either as full- or part-time assistants. And these younger men should be recruited from the general membership of the association by intercommittee work between the industrial and general association membership. Committees already established in both the medical and industrial organization could then meet to see where the consumers and producers of industrial health service could find a point of agreement.

EMERGENCY CLINICS

The many small industrial medical offices and emergency clinics now strategically located in industrial neighborhoods could be most effectively used as a nucleus for the development of health and medical services to small industries on a pooled or coöperative basis. This plan has been successfully carried out in other industrial areas of the country. The underlying pattern already exists. It means a little more detailed work on the part of representatives of industry, and a little more soul searching and education on the part of the industrial medical profession.

What type of service could be provided to small industry under such an arrangement? The small plant would be serviced by an industrial physician who would visit the plant regularly, even though it might be for only one or two hours a week. Both the workers and management would receive the basic elements necessary to health service there in the plant. In order to be able to provide these basic elements, the industrial physician who contracts to visit the establishment should have a knowledge of the industrial operations of that particular plant. He should have a knowledge of the work procedures, the environmental features, and the materials handled in the plant which might be hazardous. He should be familiar with methods for their control. This would involve keeping records of all kinds which in most cases can be handled by a nurse or clerk. But analysis and a use of the data on the records should be made by the industrial physician.

OTHER PHASES OF INDUSTRIAL MEDICINE

Every industrial physician knows that occupational injuries and diseases are responsible for only a very small portion of absence from work. Therefore, in addition to educating employees in the methods of protecting their health while at work, it would be necessary to promote good health habits among them while away from work. After all, workers spend only one-third of their day on the job. While they are out of the plant they may acquire or be exposed to acute communicable disease and on their return to work may in turn expose fellow workers to the dangers of infection. Therefore the industrial physician should coöperate with official health agencies in programs of general health education or disease prevention.

TECHNICAL COÖPERATION OF CITY AND COUNTY HEALTH DEPARTMENTS

For such technical services as are required for environmental or laboratory study of health in a plant, the industrial hygiene services of the city and county health departments will always be available. The official agencies are also available to assist and advise in regard to promotion of general health programs in industry. Perhaps this is all familiar to you. I am sure it is, for it is but a paraphrase of the objectives of Industrial Health and Medicine, as outlined by both the Council on Industrial Health of the A.M.A. and the American College of Surgeons.

Comprehensive industrial health services can be extended to small industry on a group or coöperative basis. The initiation of such a program widens the gates through which promotion of adult health can be expanded. The industrial physician is the keystone of this health program.

116 Temple Street.

MEDICAL EPONYM

Laurence-Moon-Biedl Syndrome

The eponym is applied to a symptom-complex described by Solomon Solis-Cohen and Edward Weiss in a paper, "Dystrophia Adiposogenitalis, with Atypical Retinitis Pigmentosa and Mental Deficiency—The Laurence-Biedl Syndrome: A report of four cases in one family," in the *American Journal of Medical Sciences* (169:489-505, 1925), which they thought identical with the conditions described by the authors of the papers here summarized.

In the *Ophthalmic Review* (2:32-41, 1866), John Zachariah Laurence (1830-1874) and Robert C. Moon (1846-1914) published a paper, entitled "Four Cases of 'Retinitis Pigmentosa' Occurring in the Same Family and Accompanied by General Imperfections of Development." A portion of the article follows:

"Marian T., aet. 7, 3 feet 8 inches in height, is a fat, flat-featured, heavy-looking child. . . .

"Scattered over the fundus oculi . . . were several irregular figures of a deep-black color.

"Harry S., aet. 20, is short for his age—measuring only 5 feet 3¼ inches in height. He walks with a slouching, heavy gait, as if he were tipsy.

"The superficial stratus of the choroid is considerably atrophied. . . . A few isolated dark black pigment spots are scattered over the fundi. . . .

"Frederick, aet. 18, measuring 4 feet 6½ inches in height, is a fattish heavy-looking boy. . . . Like his brother, Harry, he walks with a slouching, helpless gait, dragging his legs from the hips.

"Ophthalmoscopic examination showed exactly the same appearance as in Marian's eyes. . . .

"Charles, aet. 15, measures 4 feet 4½ inches. He is dull and inanimate, like the two other youths, and has a slouching gait, but not at all to the same extent as his brothers.

"The ophthalmoscopic description of Harry applies to this boy. . . .

"The height of each patient has been given for the purpose of directing attention to the dwarfish stature of the boys for their age. The organs of generation are also strikingly implicated in the general want of development.

"The arrest of development was by no means confined to the eye, but affected several organs of the body. In this latter point of view, and more especially when we regard the general imperfection of the mental faculties, these patients may in a certain sense be not inaptly compared with cretins in a mild degree."

In the *Deutsche medizinische Wochenschrift* (48:1630, 1922), Arthur Biedl discusses this subject at a meeting of the Prague Society of German Physicians. A portion of the translation follows:

"A brother and sister with adiposogenital dystrophy and a third patient were characterized by absence of any changes in the hypophysis or of any signs of brain tumor or pathologic intracranial pressure and by the presence of congenital malformations (retinits pigmentosa, polydactylism and atresia ani), together with limited cerebral development, shown principally by a peculiar mental torpor. In one case a diminished basal metabolism was demonstrable. . . . This new symptom-complex is to be attributed to a primary underdevelopment of the brain, especially that part of it containing the metabolism center."—R. W. B., in *New England Journal of Medicine.*

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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* For complete roster of officers, see advertising pages 2, 4 and 6.

OFFICIAL NOTICES

HOUSE OF DELEGATES: CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Forty-third (43rd) Annual Session of the House of Delegates of the California Medical Association*

First Meeting, Tuesday, May 7, 1946, in the Music Room of the Hotel Biltmore, Los Angeles

The First Meeting of the House of Delegates of the California Medical Association at its Seventy-fifth Annual Session was called to order at 4:15 P.M., Tuesday, May 7, 1946 by the speaker, E. Vincent Askey.

SPEAKER ASKEY: Will the House be in order, please? I am going to call for the Chairman of the Credentials Committee, Dr. Joseph M. DeLos Reyes.

DR. JOSEPH M. DELOS REYES, (Chairman, Committee on Credentials): Mr. Speaker, I have in my hand 110 accredited credentials to this convention and this constitutes a quorum.

SPEAKER ASKEY: One hundred and ten constitutes a quorum.

DR. DELOS REYES: I hereby make a motion that the report of this committee be accepted in lieu of roll call of this meeting.

DR. HOFFMAN: I second the motion.

SPEAKER ASKEY: Is there any discussion? If not, all in favor say "aye"; opposed "no". The motion was put to a vote and it was unanimously carried.

SPEAKER ASKEY: The motion is carried and the report of the Chairman, Dr. DeLos Reyes, of the Committee of Credentials will be accepted as the roll call of this session.

At this time the Speaker would like to explain a couple of things in regard to the conduct of the meeting. You will notice there is a small aisle back there, a division between the seats. Delegates will please have the seats in front of that division. Members of the Association who are not delegates will please have chairs back of that division so as to facilitate any voting and recognizing of Members of the House. If you will please assort yourselves now we will appreciate it.

. . . Seating of Delegates and Members. . . .

At this time your Speaker wishes to make the announcement of the committees which your Constitution and By-Laws state shall be made. The committees are as follows:

The Credentials Committee consists of Dr. Joseph M. DeLos Reyes, Chairman, Los Angeles; Dr. George Huff of San Diego was appointed but his nurse called me and he is ill in bed and unable to be present and asked to be excused. In his place I have appointed Dr. Frederick G. Gruber of Santa Monica. The other member of the committee is Dr. V. G. Ghormley of Fresno. That constitutes the Credentials Committee which will report at each meeting.

The Committees of Reference, which consist of three men each, are as follows:

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* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

Reference Committee No. 1 which has to do with the Reports of the Officers and Standing Committees and Special Committees of this House, consists of the following members:

G. Dan Delprat, Chairman; Louis J. Regan; H. F. Freidell.

In our program it also states that it is up to this committee to have the assignment of the Reports of the County Societies. This is in error, and your Chairman will apply that to another committee.

Reference Committee No. 2 which has to do with the Reports of the Council and Reports of the Secretary-Treasurer and Executive Secretary, and I am adding to that the Reports of the County Societies, consists of the following members.

E. T. Remmen, Chairman; Brodie Stephens; E. W. Page.

Reference Committee No. 3 which has charge of Resolutions, Amendments to the Constitution or Amendments to the By-Laws, and New and Miscellaneous Business, consists of the following members:

Dwight L. Wilbur, Chairman; C. B. Berne, A. E. Moore.

I want to call the attention of the Members of the House to the fact that these committees will have a great deal of work to do. It is your duty and privilege to appear before these committees and discuss any resolutions which are presented to this House in which you have an interest or on which you have information. It is not only your privilege—it is your duty. I call attention again to the fact that at this First Meeting there will be no discussion in regard to any resolution presented at this time because the rules of the House are that they must lie on the table and be presented twenty-four hours before being acted upon. This does not mean that the Chairman of the Committee reporting may not give any reasons but he may not discuss it with a view of advocacy of it. He may report what reasons his committee had for doing so because that is part of the report.

Now at this time I want to call your attention, since I am talking a little bit and making some announcements, and I will continue to make more announcements and finish it up at this time, to the fact that we have at our meeting today the California Medical Association Delegates from Fraternal Organizations, delegates from other professions who are here as our guests. I wish to introduce those men if they are here.

From the Southern California State Dental Association our guest is Francis J. Conley. Is Dr. Conley here? Apparently he is not here. I am sure he was here this morning and will be at other meetings.

From the California State Bar Association, Mr. Fred G. Reed, of Los Angeles. Mr. Reed is standing.

The second guest is Mr. William W. Vaughn, who I understand is ill. A great many of you men know Mr. Vaughn and we are sorry he cannot be here but we welcome you, Mr. Reed, very much.

The delegate from the California Pharmaceutical Association is Mr. O. V. McCracken of Bellflower. Mr. McCracken is in the back of the House and we welcome you.

The Association of California Hospitals is represented by Mr. Ritz Heerman of Los Angeles. Mr. Heerman! We welcome you.

There is another thing that I would like to call your attention to at this time; in fact there are two things. Some of you people have seen that beautiful Cadillac down in the other part of the building just above the Biltmore Bowl. I am sure you know what it is but I am going to tell you at the request of the Los Angeles County Physicians' Aid Association. This Association, as you know, is dedicated to relieving the plight of old doctors and their widows. We ask that, if you care to, you make a donation to the fund of the old physicians and if you make a donation we will see that you become the possessor of a ticket which might accidentally, if somebody happens to pick it just by chance out of the lot, win you a Cadillac. Remember, this is not a lottery; it is making a donation to this fund and you may by chance find you have a Cadillac. The tickets are available for your use at the registration desk or at other booths if you see fit to avail yourselves of them. No more need be said.

Also, I would like to ask you to buy your tickets for the President's Dinner, which will be held tomorrow night. I am afraid that many of you will not be able to be there unless you get your tickets very promptly so please do that and don't be disappointed because we are going to have a great time with Dr. Philip Gilman.

If these Fraternal Delegates would like to come forward and sit up here we might feel a little bit more capable of doing you honor. We would be happy to have you. If you would rather sit in the back, it is all right with us.

At this time I am going to introduce to you a gentleman of whom we are all proud. Some of you heard him speak this morning and many of you know him very intimately and better than I do. I know him quite well. It is a great pleasure for your Speaker of this House at this time to introduce to you your President, Dr. Philip K. Gilman. Dr. Gilman! (Applause.)

Address of President Philip K. Gilman

Mr. Speaker, Members of the House of Delegates: It is not only my privilege but a great pleasure to welcome you to this, our first full scale meeting since the war. Many of you have recently doffed the uniform of your country in which you did, as was expected, render a notable service. To those of you who were not privileged to serve with the armed forces you did equally a splendid service in meeting the vastly increased demands at home due both to our depleted ranks and the greatly augmented population. To those of you who held the line on the home front, and in addition had time to devote to the affairs of the Association should and will come the thanks of those returning members of the armed services for guarding our Association during the busy war years. By and large the returning members find our profession intact and preserved from the many assaults which confronted it.

This House of Delegates should be, and I am sure is, fully aware of the responsibilities which confront it. Upon the result of your deliberations much depends. You will be asked to make decisions that may well have a lasting effect upon the practice of medicine in California. With these thoughts to influence your deliberations, I am confident each will ponder well and together you will solve that which is best for us all. I thank you. (Applause.)

SPEAKER ASKEY: There is one more announcement which the Speaker neglected to make. Due to a typographical error in the agenda there was no place made in the Meeting of the House of Delegates for New Business and the introduction of resolutions. That was merely a typographical error and it would follow as Number 19. In other words, it follows Old and Unfinished Business, (a) Constitutional Amendments. There will be another number which will be entitled "New Business, Introduction of Resolutions."

With that change, I think our announcements will be at an end.

PRESIDENT GILMAN: Mr. Speaker, at this time I would like to ask you to request the privilege of addressing the House of Delegates by a guest speaker of our Association, Dr. James C. McCann, from Worcester, Massachusetts.

Speaker Askey: Ladies and Gentlemen of the Session, that requires unanimous consent. This is our Guest Speaker and it would be rather an insult not to hear him. Is there any objection to hearing Dr. McCann at this time? Hearing none, your Speaker grants you the privilege, Dr. Gilman, and the rule will be that it will be in order to hear Dr. McCann. Will you introduce him?

President Gilman: Dr. McCann, I would like to present you to the House of Delegates of the California Medical Association. (Applause.)

. . . Dr. McCann then read his paper. . . .

Speaker Askey: I think, Dr. McCann, that the applause shows we made no mistake in giving unanimous consent for you to address us. We appreciate your kindness in speaking to us.

At this time I wish to call your attention to the fact that our resolutions, which will be introduced later, must be presented to the House in triplicate and must be typewritten. We have stenographic service for you so if you have resolutions to present tonight, if you will see the Secretary or the stenographers, they will be triplicated and typewritten for you, so that they may be given to the House in order.

The place of meetings of the Resolutions Committee will be posted and the time of meeting will be announced tonight at the end of the session. At the end of the session this evening I wish that all Members of the Committee would meet at this table so that all instructions that your Chairman may wish to give you will be in your hands.

At this time, Dr. Dwight Murray requested me to grant him the floor. Dr. Murray!

Dr. Dwight H. Murray: Mr. Speaker, Delegates of the House: I wish at this time to ask permission to introduce to you a good friend of yours and mine who would speak to you on a very interesting subject, a subject that is very dear to your heart and for a time not to exceed three minutes:

Speaker Askey: We require unanimous consent to that. Do I hear any objection?

. . . There were cries of "Who is it?" . . .

Dr. Murray: The Honorable Charles W. Lyon. (Applause.)

Speaker Askey: The privilege is granted, Dr. Murray. Will you introduce your guest?

Dr. Murray: Thank you very much, gentlemen.

For thirty years the best interests of medicine and public health have been guarded in Sacramento by Charles W. Lyon. He has looked after your interests consistently and at all times and he has been the watchdog on the job.

For several sessions he has been the Speaker of the House, or of the Assembly, and during this time he has had opportunity to help us considerably. I say without question of contradiction whatsoever that in the 1945 Session, had it not been for Charlie Lyon leading and helping us in every way in the fight against compulsory health insurance starting in 1947 we would have been practicing medicine under an entirely different system.

Gentlemen, it is with a great deal of pleasure that I present Charles W. Lyon, Speaker of the Assembly.

Mr. Charles W. Lyon (Sacramento): Mr. Chairman, Dr. Murray, and House of Delegates: I consider this a very distinct privilege and pleasure to be able to come before you in the closing hours of your afternoon session. I shan't abridge the time, I assure you, because I know that you have much important business to transact.

I can only say to you that it is my privilege to meet you and know you. Through the years in Sacramento starting in 1915 and down to date, I have had an opportunity of meeting with your representatives there. Whether it be in the old days of Louis Ward as Secretary of the State Medical Society, before you were organized as you are today, or whether it be today when my good friend, Ben Read, comes to us with your message in the interest of proposed legislation, either for or against it, it has been my pleasure through the years to coöperate with you.

In this two or two and one-half minutes that I have I must necessarily not embark upon any extravagant speech with respect to compulsory health insurance or your voluntary plan of having that plan in this State or comment on the previous speaker's very fine remarks concerning the Massachusetts Plan, but I do say to you that America is founded upon individual enterprise and individual effort. All of the "isms" and the different regulations we have today in the Federal Government, not necessarily controlling your activities but controlling the wages of men who work, controlling the principles that influence those who produce and then that control becomes personal and gets down to you and your activities in your chosen field of science and those controls are not Americanism. They are not the things that we would vouch for nor recommend. Since the days of old Rome and the days of the old Roman Empire down to date regimentation in any form has gone hand in hand with poverty, and this government of ours was not founded upon that basis. We are a government founded upon the basis of individual enterprise and that applies to you as scientific men as well as it does to the lowest in the working field. Individual enterprise since those same days and prosperity have gone hand in hand. It is true that we have to recognize the conditions of the times and go ahead with our voluntary plan of medical service in the State of California. We must listen to those advisers who come to us with a message and out of it all try and solve our problems. Now, my time is short.

I have always tried to do the right thing in the interest of ethical medical practice insofar as my knowledge of therapy in this State was concerned, and I am so pleased at the fine response I have had in my personal ambitions to be promoted to a higher place in the Legislative Halls. After thirty years as a floor leader and as a Member of the Senate and Assembly, and now as the Speaker of that body, appointing the Committees to consider these subjects and to do all of these things, is a fine feeling for a man to have that his efforts have been appreciated and that there is a possibility that he will be promoted to a higher place. I think I have outlined that in the time that Dr. Murray has asked you to give me and to you, members of this conference here today, I thank you for your tolerance in allowing me to come to you. I shall always carry on the principles I have espoused here before your convention at this hour. Thank you very, very much. (Applause.)

Speaker Askey: Mr. Lyon, we are very happy to count you one of us. We are happy to have you here, sir.

We will now go on to the regular run of our business. We still have time this afternoon to accomplish a great deal of work, and, remember, tonight you will be getting sleepy toward the end of the meeting so we should accomplish as much as we can now.

The next is the *Report of the Council*—Philip K. Gilman, Chairman.

Dr. Philip K. Gilman: Mr. Speaker, Members of the House: There are two matters to be added to the Report of the Council as printed in the Pre-Convention Bulletin.

Item Number 1: The Academy of Pediatrics, realizing that the responsibility for child care rests primarily in the hands of physicians themselves, have launched the Study of Child Health Services in order first, to gather necessary facts from which well-founded plans can be evolved, and second, to determine the extent and quality of services now available. Thus the physicians, unquestionably the ones who know what constitutes good care and who for the most part provide that care, have accepted the challenge to develop constructive plans for medical service to children. (See page 405.)

The administration and conduct of the study in each state will be under the direction of the Academy State Chairman, who with the help of one or more full-time Executive Secretaries, will organize the program and correlate all the many activities involved in the survey.

I may say, in a word of explanation of the job about to be undertaken, this communication from the State Chairman, Dr. Crawford Bost was unanimously approved by the Council and is now added to the Report of the Council.

SPEAKER ASKEY: It will be referred to Committee Number 2, with the regular Report of the Council.

DR. GILMAN: The second discussion had by the Council is that there is to be added to that report a resolution.

WHEREAS, The medical profession in the United States is irrevocably opposed to compulsory health insurance and government control of the physician-patient relationship, but the medical profession, however, wholeheartedly supports the national medical care program adopted by the Board of Trustees of the A.M.A.—a program calculated to bring prepaid medical care to the American people on a voluntary free enterprise basis, and

The story of medicine's deeds and acts in the field of prepaid medical care is not being effectively told to the public or Congress, and

If government controlled medicine is to be prevented it is imperative that a united front of all business, agriculture, labor, veterans and other groups and organizations that are in favor of free enterprise and the American system be established immediately, and

The medical profession must take the lead in creating a united front and in the coördination of all such groups and organizations to the end that an effective campaign be prosecuted with vigor, and

It is likewise imperative that action be taken now—tomorrow may be too late. Now, therefore, be it

Resolved, (1) That the American Medical Association immediately secure the most competent and experienced legislative representative that can be found to represent the Association at Washington, D. C.—instead of the skeleton set up now sometimes used:

(2) That such representative be given complete authority and full coöperation, financial and otherwise, in the carrying out of the policies of the American Medical Association, including the establishment of a united front against government controlled medicine:

(3) That the most competent and outstanding public relations counsel that can be found in the United States be employed immediately to bring to the American public the real story of medicine and the cost of medical care.

(4) That the national medical care program adopted by the House of Delegates of the American Medical Association and by the Board of Trustees of the American Medical Association immediately be implemented by sufficient appropriations of funds of the American Medical Association to permit the program to be established by those state medical societies that have not as yet been able to establish prepaid medical care programs and to permit a real nationwide furthering of existing and flourishing prepaid medical care plans.

(5) The foregoing plan of action should replace all of the existing organizations that are endeavoring to do legislative work on a national scale.

SPEAKER ASKEY: It will be referred to Committee No. 2 as a part of the Council's report. With these additions, the full Council Report will be referred to Reference Committee Number 2.

At this time we will hear the *Report of the "Trustees of the California Medical Association"* which will be given by Dr. Philip K. Gilman. Dr. Gilman, please.

DR. GILMAN: There is nothing to add, Mr. Speaker, to the Report as printed in the Pre-Convention Bulletin.

SPEAKER ASKEY: There being no further additions, the Report as printed will be referred to Reference Committee Number 2.

The next is the *Report of the Auditing Committee,* John W. Cline, Chairman.

DR. JOHN W. CLINE: There are no additions to the Report.

SPEAKER ASKEY: There being no additions to the Report, this Report will be referred to Reference Committee Number 1.

The next is the *Report of the Secretary,* George H. Kress.

DR. GEORGE H. KRESS: No additions.

SPEAKER ASKEY: There being no additions, it will be referred to Reference Committee No. 2. It is so referred.

The next is the *Report of the Executive Secretary,* John Hunton.

MR. JOHN HUNTON: There are no additions to the report.

SPEAKER ASKEY: There are no additions. The report as printed will be referred to Reference Committee No. 2, according to the By-Laws.

The *Reports of the County Societies,* as I stated before, are being referred to Reference Committee Number 2.

The next is the *Report of the Editor.* At this time before we take the Report of the Editor, Dr. Kress, I wish to call attention to the fact that printed in the agenda is a statement and it is noticed that there will be a meeting of the California Physicians' Service, Administrative Body at 8:30 tonight. At this time I am calling your attention to the evening meeting at 8:30 which will be a meeting of the Administrative members of the California Physicians' Service and I should remind you that the Administrative Body of the California Physicians' Service consists of all of the Members of the House of Delegates, but in addition it also has some lay members and in order to meet the legal requirements the meeting must occur at the time which was stated, 8:30 tonight. We will then go on with the rest of our program, and as I stated before, the next is the Report of the Editor, Dr. Kress.

DR. GEORGE KRESS: There are no additions.

SPEAKER ASKEY: There being no additions to the Report of the Editor, it is referred to Reference Committee Number 1.

The *Reports of the District Councilors.* Do any of them have anything else to add to their published reports? I hear none and the Reports of the District Councilors are referred to Reference Committee Number 1.

The *Reports of the Councilors-at-large.* Are there any Councilors-at-large who wish to make additions to their reports as published? I hear no request for an addition. The Reports as published are hereby referred to Reference Committee Number 1.

The *Report of our General Counsel* will now be heard. Now our General Counsel, as you know, consists of the firm of Peart, Baraty & Hassard. At this time I would like to introduce Mr. Peart to you. I am not going to allow him to speak because he isn't able to, but I would like to have him take the applause of the audience. (Applause.)

It was at Mr. Peart's request that I asked him not to speak. He would be happy to speak and we would be happy to have him, but due to his throat condition he requested not to speak. He asked me to let his associate Mr. Hassard speak for him. Will you report for your firm, Mr. Hassard?

MR. HASSARD: Mr. Speaker, and Members of the House of Delegates: The Annual Report of the Legal Department is printed in the Pre-Convention Bulletin. New matters have arisen since then, but they are included in other reports that will come before the House. There is lots of work to do and let's proceed with it. (Applause.)

SPEAKER ASKEY: Thank you, Mr. Hassard.

The Report of your General Counsel is hereby referred to Reference Committee Number 1.

We will have the *Reports now of our Standing and Special Committees.* The *Standing Committees* are first.

The *Executive Committee*—John W. Cline, Chairman. Do you have any additions?

Dr. Cline: No additions to report.

Speaker Askey: There being no additions, the report of the Executive Committee is hereby referred to Reference Committee Number 1.

The *Committee on Associated Societies and Technical Groups*—John V. Barrow. Are there any additions to your report, Doctor? Doctor Barrow, not being here, and I hear no additions, it is referred to Reference Committee Number 1.

The *Committee on Audits*—John W. Cline. Are there any additions?

Dr. Cline: There are no additions to the report.

Speaker Askey: There being no additions, the report is referred to Reference Committee Number 1.

The *Committee on Health and Public Instruction*—J. C. Geiger. Is Dr. Geiger here? Hearing no additions, the report as printed will be referred to Reference Committee Number 1.

The *Committee on History and Obituaries*—Morton R. Gibbons, Sr. Is there an addition? I hear none, and the report as printed is referred to Reference Committee Number 1.

The *Committee on Hospitals, Dispensaries, and Clinics*—Clarence E. Rees.

Dr. Rees: No additions to the report.

Speaker Askey: If there are no additions to the report, the report as printed will be referred to Reference Committee Number 1.

The *Committee on Industrial Practice*—Donald Cass. Are there additions? I hear no additions, so the report as printed will be referred to Reference Committee Number 1.

The *Committee on Medical Defense*—Nelson J. Howard. Are there any additions to the report? If not, it will be referred to Reference Committee Number 1.

The *Committee on Medical Economics*—H. Gordon MacLean.

Dr. MacLean: No further report.

Speaker Askey: It is referred to Reference Committee Number 1 as printed.

The *Committee on Medical Education and Medical Institutions*—B. O. Raulston. Are there any additions to the report? I hear none—it is referred to Reference Committee Number 1, as printed.

The *Committee on Organization and Membership*—Carl L. Mulfinger. Is there an addition, Dr. Mulfinger?

Dr. Mulfinger: No additions to the report itself.

Speaker Askey: It is referred to Reference Committee Number 1 as printed.

The *Committee on Postgraduate Activities*—F. E. Clough.

Dr. Clough: No additions to the report.

Speaker Askey: It is referred to Reference Committee Number 1 as printed.

The *Committee on Publications*—George W. Walker.

Dr. Walker: No additions to the report.

Speaker Askey: No additional report, the report will be referred to Reference Committee Number 1 as printed.

The *Committee on Public Policy and Legislation*—Dwight H. Murray. Dr. Murray!

Dr. Murray: No additional report.

Speaker Askey: It is referred to Reference Committee Number 1.

The *Committee on Scientific Work (Annual Session)*—George H. Kress. Dr. Kress!

Dr. Kress: No additional report.

Speaker Askey: It is referred to Reference Committee Number 1.

The *Cancer Commission*—Lyell C. Kinney. Is there an additional report, Dr. Kinney?

Dr. Lyell C. Kinney: As I said in the report made to the Council yesterday, there is no additional work.

Speaker Askey: I may say Dr. Kinney has made a remarkable report which you will hear later. The report will be referred to Reference Committee Number 1.

The *Editorial Board*—Albert J. Scholl. Are there any additions? I hear none, the report as printed is referred to Reference Committee Number 1.

We have come now to *Special Committees*, the first being that of the *Special Committee on Prepaid Medical and Hospital Care*—L. R. Chandler. Dr. Chandler, do you have an additional report?

Dr. L. R. Chandler: I am going to make a report.

Speaker Askey: Dr. Chandler!

Committee on Prepaid Medical and Hospital Care

L. R. Chandler, *Chairman*

Mr. Speaker, and Members of the House: Taking at face value the Speaker's reminder that the Chairman may present a report and as a matter of explanation discuss from the point of view of the committee's action, I would like to go into the Report.

First, this committee met regularly from last summer and finally arrived at this group of recommendations to be considered by you on the basis that 80 per cent or more of the doctors of California should be able to support some kind of a program of voluntary prepaid medical care. The committee appreciates, I know, in all of its deliberations that these specific recommendations are not final but they are recommendations for your consideration and amendments in any way that you choose.

I would like to have you turn to recommendation Number 1.

Speaker Askey: Dr. Chandler, just a second. For the purpose of aiding the Members, the report is on page 31 of your Annual Sessions Reports, and if you turn to that you may follow Dr. Chandler a little bit easier.

Dr. Chandler: (1) There should be a service type of benefit for the lower income group, an indemnity type of service or contract or an arrangement for the group above some agreed income level.

I think the committee was unanimous in its feeling that should be done. It is difficult to sell the boys in the back room of organized labor when you can't sell the front office. It is more comprehensive and applies to more people in the State of California and it has an opportunity to be sold to more people. That was the unanimous opinion of the committee.

Likewise, Number 2. That fees paid to physician members for the fee-for-service type of contract for the lower income group should be the only fee paid by the subscriber and the only fee received by the doctor rendering the service for that group. Back of that is a long and very illuminating conference with representatives of four employer groups in California, and those employer groups represented some 3,000,000 employees. Our committee had the impression, in fact a distinct understanding that employers are willing and anxious to pay in one of two or three ways for prepaid medical care for non-industrial illness or accidents, if their low income group employees can choose their own doctors and have only the one fee to pay.

Now Number 3 was the unanimous recommendation, of course, that the method of payment on the open panel, or free choice of physician program be changed from a designation of unit to a scale of dollars. There has been vigorous and bitter complaint about that.

Number 4, that the physician member be entitled to arrange for an additional fee for subscribers whose income is above an agreed upon income level is already in practice in California and it seems to be a reasonable recommendation together with the three previous ones.

Number 5 is that the beneficiary, irrespective of whether he is in the low income group or above that level, be permitted a free choice of doctor. The committee debated that a long time and in using the words "licensed physician and surgeon" realized that there are osteopathic physicians and surgeons licensed in this State and that some people who might wish to subscribe and do subscribe would choose such a practitioner. That recommendation was given further consideration. I think it would be a fair statement for the Chairman to state that the committee doesn't feel very bitter either way by the inclusion or the exclusion of osteopathic physicians and surgeons, but it gives a broader choice of physicians on the part of the subscriber if he chooses to do it. It is done in some other states.

Number 6, that all physicians receive the same fee according to the fee-for-service schedule.

Now, obviously, there is bad wording there on the part of the committee which will be amended. I am sure, in the Reference Committee. That means that the fees received from C.P.S. should be the same fee according to the fee schedule, if there is to be a fee schedule and that the low income subscriber pays one fee which is a monthly deduction, and the doctor receives a professional fee from the low income group on an agreed fee schedule. Then our committee means what this says, that inclusion means that all physicians rendering services to this low income group receive the fee agreed upon in the fee schedule.

Number 7, means, of course, that the fee schedule should be revised from time to time. Economic changes do occur and our guest speaker this afternoon presented you some figures from Massachusetts. We have available at the committee some figures and reports from Massachusetts, which were rather surprising to some of us, but our recommendation basically is that the fee schedule should be established by the doctors themselves rather than the administrative manager, or even the Administrative Board, and that the doctors themselves should set this fee and that it can be done and should be done. I think a fair statement of the committee's feeling is that the present fee schedule is not bad. It is not particularly out of line except for men in internal medicine or general practice, but the fee schedule and the established method of its administrative problems is within C.P.S. We would like to see some action taken that would create that fee schedule by the doctors outside of the organized administrative body itself.

Now, Number 8, again, is a recommendation that was arrived at after considerable thought and discussion and reviewing of information made available to us. Where should the income level be established that will provide a fee-for-service group and those that are on the cash indemnity basis? The figure reported to you is $2,400.00 annual gross income for an individual without dependents and $3,000.00 annual gross income for individuals with dependents. That was the unanimous recommendation of the committee. Keep in mind at that point the higher the income level is set for the all-inclusive fee-for-service, the more people will buy it. The lower it is set the more pleased the doctors may be, but somewhere between those two extremes the committee was convinced that there is an acceptable level and, if that isn't it, then you establish it in your discussions of it Thursday.

Number 9 is the tough one. May I remind you that with C.P.S. it goes back a long ways. It was obvious that in the beginning it was a complete all-inclusive service and was established for various reasons, not the least of which was an experiment run by doctors to gather information and we got information. It was obvious that medical service must go hand in hand with hospital service and it should be on a state-wide basis.

As you know, there are three hospital service agencies in California, each one a little bit different, each one selling just a little bit different contract. I think the fees are even a little bit different and their managements and organizations are different. It seemed absolutely essential to this committee that medical service and hospital service go hand in hand. Now, if it cannot be arranged by the three hospital service agencies themselves, or between them and the California Hospital Association, or any other arrangement that they wish to make, the committee is of the opinion that the California Physicians' Service should go it alone and sell one package rather than to continue on a divided basis. That is a rather vigorous recommendation but it seems to the committee that something could be done and it should be done, and if it can't be done on a voluntary basis that medical service should go it alone and include hospital service.

Now, Number 10 is a recommendation that we believe is fitting and proper. Without specifically shooting at any particular Board of Trustees or any particular manager of C.P.S., the committee was unable to find a report of a complete or satisfactory survey made by competent surveyors of the present program. It had been studied by many people, but whether or not actuarial experiences and financial, business and operating procedures in the organizations are complete or the best that can be or should be modified, that we were not certain. The committee didn't consider it could proceed to be that judge but there were a number of complaints, many of them based on inadequate information, some of them on misinformation, but without such a survey the committee felt that such a recommendation as Number 10 was in order; that such a survey should be made. If we need changes then we should have them. If we don't need any changes then the fellows who have been complaining their heads off and making suggestions should have an expert advise them that none are needed.

Number 11 is a recommendation that the Board of Trustees be enlarged to fifteen members on the basis that we expect industrial employer groups to become very much interested in this and some of us will be very much surprised if industry itself does not include any prepaid care as an operating expense for all of its employees if something of this kind is the result of this House of Delegates. For that reason the recommendation is made that the Board of Trustees be enlarged to fifteen members, and that is the suggestion, and that these additional places be filled by experienced business administrators and executives from the business world.

Number 12. It is the committee's belief that there has been too much interference by too many people with the business administration of the C.P.S. I am sure that the committee, although I can't recall any exact vote being taken on this particular point, is of the opinion that the C.P.S. organization is the business organization to sell and run medical care. They should have a free hand with the support of the medical profession of the State of California, a free hand to run the details and administration and executive branches of its own organization.

Number 13. The director or directors of the California Physicians' Service, as many of you know, have come in for a good share of roasting. Now in studying the problem, not only C.P.S. and its behavior in California was taken into consideration, but we had available the reviews of twenty-three other state service organizations and it is not clear to the committee whether or not all of the things that medical directors do in California are essential to the conduct of good business; whether they are less than the desired amount, and whether there should be two directors or a half-time director, or no director. We think these activities should be reviewed critically, keeping in mind that California has pioneered this program and that there is in C.P.S. at the present time a medical administrator who has grown up with it and that California in taking the lead may be way out in the lead.

The committee recommends, however, that this question be reviewed without any prejudice in making such a recommendation.

Number 14 is of no great concern; that the term "professional member" be changed to "physician member."

Number 15, we believe, is important. A good part of the half-hearted support and in some instances negative support by the physicians of C.P.S. has been on the basis of inadequate information on the part of the doctors. All the committee recommends is that every effective means be employed to keep the physicians of the State of California informed as to its activities, the financial status, the problems, the service in the office and that sort of business. It cannot be done in the opinion of the committee effectively by any throw-away sheet that is published and mailed around the State. It will have to be done by some method of personal contact within the administration of C.P.S.

Lastly, that the California Medical Association and its individual members, you and I, if we believe in this, continue our sponsorship of the California Physicians' Service and a voluntary system of prepaid medical care, coöperating with the A.M.A. and so forth. You will note that we specifically do not define everything that should be included in the prepaid voluntary, prepaid medical care system, but in its discussions the committee included not only the prepaid free choice of physician represented by C.P.S. but also private insurance companies selling a cash indemnity type of contract or a group contract that may choose to sell prepaid medical care. We avoided including any definition of what the House of Delegates in the State Societies had included but those were our thoughts and those were our discussions.

Mr. Speaker, without reading it in detail, I submit this report as a unanimous report of our committee. (Applause.)

Speaker Askey: The report of this committee will be referred to Reference Committee Number 1.

The *Committee on Postwar Planning*—Harold A. Fletcher. Is there an additional report? There being no additional report, the report as printed will be referred to Reference Committee Number 1.

The *Committee on California Physicians' Service*—Chester L. Cooley. Is there a report in addition, Dr. Cooley? I hear none; that report as printed will be referred to Reference Committee Number 1.

The *Committee on Delegates to the American Medical Association*—Dwight H. Murray. Is there an additional report, Dr. Murray?

Dr. Murray: No additional report.

Speaker Askey: The report as printed will be referred to Reference Committee Number 1.

The report of the *Committee on Physicians' Benevolence*—Axcel E. Anderson.

Dr. Anderson: No further report.

Speaker Askey: The report is referred to Reference Committee Number 1.

The *Committee on Participation of the Medical Profession in the War Effort: Procurement and Assignment Service*—Harold A. Fletcher. Is there an additional report? There is none—it is referred to Reference Committee Number 1.

The *Advisory Planning Committee*—John Hunton.

Mr. Hunton: No additional report.

Speaker Askey: It will be referred to Reference Committee Number 1.

The *Committee on A.M.A. Session in San Francisco, July 1-5, 1946*—John W. Cline.

Dr. Cline: No additional report.

Speaker Askey: No additional report. That report is printed and it is referred to Reference Committee Number 1.

The *Committee on Local Arrangements—C.M.A. Annual Session*—E. T. Remmen.

Dr. Remmen: No additional report.

Speaker Askey: That report will be referred to Reference Committee Number 1.

Liaison Representative to California Veterans' Committee—Frank A. MacDonald.

Dr. MacDonald: No additional report.

Speaker Askey: That will be referred to Reference Committee Number 1.

Advisory Committee to the California Bureau of Vocational Rehabilitation—John W. Cline.

Dr. Cline: After the publication of the report which you will find in the Pre-Convention Bulletin, there was a meeting of the Advisory Committee. I think for just a moment I would like to tell you something of the program of the Vocational Rehabilitation Bureau. The physical restoration program is designed to carry on beyond the crippled children's program. It is primarily to restore to an employable status or to improve the employability of the people who are suffering from physical handicaps. As the federal regulations are drawn, they are so loose and can be so extensive that this program can well become stymied by the back door. It is a program which has very worthy purposes and if it is carefully restricted and carefully supervised it can fulfill an excellent place. It can do a good job to restore as employable certain people who otherwise would be economically unsuccessful and a charge on the community. The program includes the care of people who have static conditions which can be remedied in a period which is considered to be about ninety days, or a reasonable period. It provides only for those people who can be rehabilitated and it also is limited to people who cannot obtain such care by other means. The program, therefore, has not yet become extensive in large urban centers. Los Angeles, San Francisco, Alameda and other counties with large, well organized and well stocked county institutions have carried the brunt of this program in their counties because they were able to care for those people. It is true that the bulk of the applicants under this program are indigent or medically indigent. However, the program as organized and operated up to the present time has shown a tendency in certain places to extend the employment requirements to a point which is inimical to the welfare of the individuals in the practice of medicine. Furthermore, there has been an inconsistent application of the rules and regulations governing the program through the State and there has been a tendency for the lay officers, the rehabilitation officers, to undertake medical decisions in a way that should not be done.

Therefore, the Advisory Committee, meeting with the responsible State officers, made certain definite recommendations to them and the first one was that if the Advisory Committee was to have a function it should advise, and if it were not in a position to advise and have its advice listened to and accepted, it should disband and no longer serve the agency.

The Advisory Committee then went on to make specific recommendations with which I will not bore you but which I think will bring about a certain improvement in the administration of the program and throw certain safeguards about it. I think it is well, however, for the Members of this House to observe the operation of this program in their own community because of the possible hazard that it presents.

Speaker Askey: The Report of the Committee will be referred to Reference Committee Number 1.

The *Committee on Maternity-Pediatric Plan of Federal Children's Bureau*—Karl L. Schaupp. Is there an additional report? If not, the report is referred to Reference Committee Number 1.

The *Committee to Meet with Representatives of Seventeen Midwestern States*—Philip K. Gilman. Dr. Gilman, is there an additional report?

Dr. Gilman: May I take just a minute? Last June in Denver representatives of California met with representatives of these other states and at that time there was born a new organization, the Conference of State Presidents. The second meeting of that organization was held in Chicago on the Sunday preceding the meeting of the House of Delegates of the American Medical Association. At that time resolutions adopted by that Conference of State Presidents, were submitted to the House of Delegates of the American Medical Association and all of them passed. The next meeting of the Conference of State Presidents will be in San Francisco on Sunday afternoon on the 30th of June, immediately preceding the meeting of the American Medical Association. At that time the President of the Organization, Dr. Andrew Brunk, of Michigan, will preside and all are invited to attend this meeting whether they be presidents or other officers of the State Medical Association.

Speaker Askey: Dr. Gilman neglected to state that the President-Elect of the Conference of State Presidents is Dr. Philip K. Gilman of our State. He is President-Elect of this new association and he is doing a great work there.

This report will be referred to Reference Committee Number 1.

The *Committee on Adoption Laws—California State Department of Social Welfare*—George H. Kress. Dr. Kress!

Dr. Kress: No additional report.

Speaker Askey: This Report is referred to Reference Committee Number 1.

The next order of business is Old and Unfinished Business. There was last year placed before this House a Constitutional Amendment which will be found on page 21 of your little program here. I will ask the Secretary to read that and it will be placed before this House for action at this year's session.

Dr. Kress:

Proposed Amendment to C.M.A. Constitution Re: Ex-Officio Members of Council

Be it Resolved, That the first paragraph of Section 1, Article VII, of the Constitution of the California Medical Association be amended to read:

"The Council shall consist of the Councilors, and ex-officio; the President, the President-elect, the Speaker and Vice-Speaker of the House of Delegates, each with all the rights of a Councilor"; and, be it

Resolved, That the first paragraph of Section 4, Article X of the Constitution of the California Medical Association be amended to read:

"The President, President-elect, the Speaker and Vice-Speaker of the House of Delegates shall be ex-officio members of the Council with all the rights of Councilors."

Speaker Askey: You have heard the Constitutional Amendment which was placed before this House last year. It has been properly published as required by the Constitution and is hereby by reading by the Secretary placed before you for action. It is referred to Committee Number 3.

I may call your attention to the fact that the recommendations of this committee will be heard but no amendment to this amendment may be made because it must be voted exactly as it was published and is presented. The recommendation of the committee may be heard as to what we should do. It is referred to Reference Committee Number 3.

At this time I am going to call attention to the fact that the committees have announced the time of their meeting.

Committee Number 1, Dr. Delprat's Committee, will meet at 10:00 o'clock tomorrow morning in Room 6227. That committee has the report of Dr. Chandler's committee and all of those things in which you are interested.

Reference Committee Number 2, which has the Report of the Council, the Secretary-Treasurer and the Executive Secretary is in room 9204, at 10:00 o'clock tomorrow morning, Wednesday.

Dr. Wilbur's committee which will be the Resolutions Committee and the Constitution and By-Laws Amendments, will meet tomorrow morning at 10:00 o'clock in the Galeria Room opposite the Music Room. Resolutions, I may say at this time, may overlap; in other words, resolutions which may be introduced to this body tonight may overlap in their reference to something which has already been placed before Committee Number 1. If in the view of the Speaker or if in the opinion of the Chairman of Committee Number 3, it does overlap it will be referred to Committee Number 1 or the appropriate place so that consideration should all be in a line; in other words, it would not be good policy to have two committees considering the same problem at the same time.

It is my belief that you gentlemen and ladies need some sustenance and we have before us, for the rest of this meeting, as I told you, the introduction of any resolutions and new business and the meeting of the C.P.S. Administrative Body, so a motion to recess until 8:00 o'clock this evening is now in order at this time.

Dr. Bruck: I move we recess until 8:00 o'clock this evening.

Dr. Boyle: I will second the motion.

Speaker Askey: It has been moved and seconded that we recess until 8:00 o'clock this evening to reconvene in this room. All those in favor say "aye"; those opposed, "No."

. . . The motion was put to a vote and was unanimously carried. . . .

. . . The meeting recessed at 5:50 P.M. to reconvene at 8:00 o'clock P.M. . . .

Post-Recess Session of First Meeting of House of Delegates

. . . The First Meeting of the House of Delegates resumed at 8:10 P.M. . . .

Vice-Speaker Alesen: The House will come to order. The House is now open for the reception of resolutions under New Business. In presenting resolutions will the Delegates please give their name distinctly in order that the Secretary may have a record of it and also the name of their county society.

Dr. Carr of San Francisco.

Dr. Jesse L. Carr (San Francisco): All of these resolutions emanate from the delegation of the San Francisco Group excepting one which is proposed by Dr. John Cline, and they are, to-wit:

Resolution Number 1:

Whereas, A group of California insurance companies have combined together to form a California Health Conference and have, under the name "California Plan" proposed to sell to the public voluntary health insurance contracts on an indemnity basis; and

Whereas, the informative literature describing the California Plan does not clearly state the fact that members of the public who may purchase California Plan insurance policies will receive a cash indemnity limited to the amount set forth in a fee schedule, which indemnity may or may not coincide with the attending physician's reasonable charge for his services; and

Whereas, The lack of clarity in the explanatory literature of the California Plan on this point can well become a cause of confusion and misunderstanding between physicians and their patients, thus injuring rather than furthering the cause of voluntary health insurance; now, therefore, be it

Resolved, That the California Medical Association is completely in favor of all approved voluntary prepaid medical care plans, whether on an insurance indemnity basis or medically-owned free choice service basis; and be it

Further Resolved, That all voluntary health insurance plans operated on an indemnity basis, to be approved or supported by this Association must include in all policies or contracts issued and in all advertising and promotional literature clear and understandable statements to the public that the fee schedules upon which cash indemnity is based represent only the indemnification allowed by the Insurance Carrier for the particular service rendered but do not necessarily represent professional charges; and, be it

Further Resolved, That a copy of this resolution be forwarded to the California Health Conference by the Secretary of this Association, in order that the California Health Conference may be fully advised of the position of this Association with respect to voluntary health insurance and insurance indemnities against the cost of medical care.

VICE-SPEAKER ALESEN: That resolution will be referred to Reference Committee Number 3.

DR. CARR:

Resolution Number 2:

WHEREAS, Dr. Dwight Murray as chairman and the legislative committee as a whole, give freely of their own time and energy in the interest of the California Medical Association and whereas members of the California Medical Association and the profession deeply appreciate these efforts; therefore be it

Resolved, That Dr. Murray and his committee be commended for their splendid work during the past year and a vote of confidence be extended the Chairman and the committee for the administration of these affairs. (Applause.)

Resolution Number 3:

From the San Francisco delegation.

Resolved, That the House of Delegates of the California Medical Association hereby urges every member of the Association to become and remain a physician member of California Physicians' Service; and be it further

Resolved, That a copy of this resolution be forwarded to every component county society and be published in every issue of CALIFORNIA AND WESTERN MEDICINE during the ensuing year.

Resolution Number 4:

From the San Francisco delegation.

WHEREAS, The large proportion of the doctors in the State of California are members of California Physicians' Service, and whereas most of the doctors in the State of California appeal to their confreres and contemporaries for medical aid in the case of sickness in their own families, office staffs, *domestic* and *other employees;* and

WHEREAS, These services are always gratuitous and constitute a drain on the attending physician; be it therefore

Resolved, That all members of the California Medical Association be advised to join California Physicians' Service as beneficiary members; and, be it

Further Resolved, That California Physicians' Service extend to these members the same complete coverage as that offered in group policies.

Resolution Number 5:

From the San Francisco delegation.

WHEREAS, The technique of a corneal transplantation in the science of eye surgery, and the use of cartilage implants for plastic repair in plastic surgery have reached a high level of technical attainment; and

WHEREAS, There are now some thousands of wounded veterans residing in veteran hospitals in the State of California and elsewhere, many of whom require plastic surgery, in addition to growing civilian needs, and where operative technique is now at a standstill because of lack of these fundamental materials for their plastic reconstruction; and

WHEREAS, The ultimate restoration of these veterans to normal civilian life may not be completed until such materials are available; be it therefore

Resolved, That the California Medical Association instruct its legislative committee to promote constructive legislation to legalize the willing of either a whole or a part of one's body to a recognized institution for subsequent use of any whole or parts of that body for designated reconstructive purposes.

Mr. Chairman, is it in order at this time to offer an Amendment to the Constitution?

VICE-SPEAKER ALESEN: Amendments may be received but they will lie on the table for one year.

DR. CARR: This Amendment to the Constitution is introduced by Dr. John Cline and not by the San Francisco delegation.

Be It Resolved, That Section 12 of Article X of the California Medical Association is hereby repealed.

VICE-SPEAKER ALESEN: The resolutions submitted by Dr. Carr will be referred to Reference Committee Number 3, and the Constitutional Amendment will, of course, lie on the table for one year.

Are there others, who wish to introduce resolutions at this time?

DR. ERIC A. ROYSTON (Los Angeles):

Resolution Number 6:

WHEREAS, A very large number of the members of the California Medical Association are engaged in the general practice of medicine; and

WHEREAS, These members are desirous of associating themselves more closely together so they may attain a better realization of the importance of their position in the Science of the Healing Art; and

WHEREAS, There already is in the Los Angeles County Medical Association a well functioning section on general practice; and

WHEREAS, The American Medical Association has already recognized the status of its members engaged in the general practice of medicine by establishing in the A.M.A. a section on general practice; therefore be it

Resolved, That the California Medical Association, through its House of Delegates, authorize the formation in the C.M.A. of a section on general practice; and further be it

Resolved, That arrangements be made at this session of the C.M.A. for the election of the officers necessary to the proper functioning of this newly formed section.

VICE-SPEAKER ALESEN: This resolution will be referred to Reference Committee Number 3.

Dr. William Benbow Thompson!

DR. WILLIAM BENBOW THOMPSON (Los Angeles County):

This is an amendment to the Constitution proposed by the Los Angeles delegation.

Resolution Number 7:

WHEREAS, The California Medical Association is now in a sound financial position having liquid assets in excess of $400,000; and

WHEREAS, The acquisition of large sums of money by the State Association may lead to loss of its status as a non-profit corporation, particularly if the Association participates in political campaigns or in attempts to influence legislation; and

WHEREAS, The accumulation of great wealth by the California Medical Association will inevitably lead to the submergence and loss of independence and authority by the component county associations, just as the states of the Union have lost prestige and authority as the wealth of the Federal Government has increased; and

WHEREAS, It is obvious that as state dues increase there must be a proportionate reduction in county dues, thereby hampering and crippling important activities of the County Associations, which are the vital foundation of organized medicine; and

WHEREAS, The high state dues of the past year caused a material number of members to terminate their membership because of inability to pay such dues, and many others have signified their inability or unwillingness to pay similar dues next year; therefore be it

Resolved, That it be the policy of the House of Delegates to fix annual dues at not more than $35.00 unless higher dues have been approved by a referendum vote of the members of the California Medical Association.

VICE-SPEAKER ALESEN: This Constitutional Amendment will lie upon the table for one year and will be published in CALIFORNIA AND WESTERN MEDICINE.

Dr. DeLos Reyes!

Dr. Joseph M. DeLos Reyes: I am presenting this resolution in behalf of some of the members of the Los Angeles County Medical Association.

Resolution Number 8:

Whereas, The large number of enlisted personnel who have been discharged from the medical corps of the Army and the Navy, it is timely and advantageous both to the medical profession itself and as a public service to the discharged enlisted men and women to begin an active program for utilization of this pool of potential medical students, laboratory technicians and assistants in hospitals and in the private practice of medicine; and

Whereas, Time is of the essence in this problem, we should begin an active program for the development of the less spectacular, but, nevertheless, highly important members of our medical team in order to provide the personnel necessary for the carrying on of the tremendous problem of increased medical care which present trends in preventive medicine and socio-politico economic movements are presenting to us as a medical profession and to which the general public is being educated to expect and to demand; be it

Resolved, That the Committee of Postgraduate Education, working with the various medical schools, develop a program to provide assistance, encouragement and advice furthering the placement of this type of personnel in colleges, hospitals or laboratories where they may complete their training and education to the best of their ability and capacity.

Vice-Speaker Alesen: This will be referred to Reference Committee Number 3.

Dr. William M. Makaroff (Sonoma County):

Resolution Number 9:

Whereas, Facilities for postgraduate medical studies are at the present time mainly limited to regular staff appointments on already crowded teaching hospitals and require appointments for from one to several years in the fulfillment of requirements for specialized training; and

Whereas, A great many of the doctors returning from service in the Armed Forces are unable, either because of financial limitations or because of time already lost from active practice, and feel it is impracticable to devote long periods of postgraduate study; and

Whereas, The burden of practice on a great many physicians who have remained engaged in active civilian practice in our State during the war period have been unable to devote appreciable time to postgraduate study; and

Whereas, It is felt that an added impetus to furthering the improvement in the quality of medical practice in our State by assisting the individual physicians in improving their general and specific knowledge and training in both general and special fields of interest; be it

Resolved, That the Committee on Postgraduate Education and Scientific Development begin active planning toward the establishment of facilities whereby continuous course in medicine, surgery and their related specialties consisting of instruction and hospital training in designated hospitals in the larger metropolitan centers. It is suggested that hospitals be selected which are not already engaged in active organized medical training, but which have well organized medical staffs and facilities, who, working together with the already functioning medical schools in the State, may give courses of instruction, assisted by the faculties of the medical schools, ranging from two weeks to three months period for the individual postgraduate student. And that costs of said organization to be jointly shared by tuition charges, funds allocated by the C.M.A. and funds which may be provided from the various medical schools, medical alumni organizations and/or individuals.

I am sorry now, gentlemen, that the hour of 8:30 has arrived. This organization will recess to be taken over by the meeting of the Administrative Members under the chairmanship of Dr. Lowell S. Goin. The meeting stands recessed until the completion of the meeting of the California Physicians' Service at which time you will be called to order by your Speaker, Dr. Askey.

. . . After 8:30 P.M. the meeting of the House of Delegates recessed. . . .

(The House of Delegates, together with elected Administrative Members, then sat as the Administrative Members of California Physicians' Service. Minutes of this meeting will appear in the next issue of this publication.)

* * *

Post-Recess Meeting of C.M.A. House of Delegates

. . . The House of Delegates reconvened at 8:50 P.M. . .

Speaker Askey: We are now out of recess and in session as the House of Delegates of the California Medical Association.

Dr. Keiper, if you wish to present a resolution to the House of Delegates it is now in order and I will give you the floor, sir.

Dr. George Keiper (Tulare County): Referring to the Report of the Committee on Prepaid Medical and Hospital Care of March 31, 1946, specifically with reference to page 3 recommendation 5 follows:

Resolution Number 10:

That the beneficiary members be free to choose any licensed physician and surgeon which includes an osteopathic physician and surgeon and that C.P.S. make payment to any physician chosen by the beneficiary whether or not such physician is a physician member of C.P.S.; now

Whereas, Such inclusion of osteopathic physicians and surgeons is distinctly objectionable from an ethical standpoint both as to training and licensing; and,

Whereas, Osteopathic physicians and surgeons have repeatedly attempted equal rights and privileges in the practice of medicine; and

Whereas, Those privileges are now denied in standard medical approved hospitals; and

Whereas, Most small communities do not now have sufficient hospital beds for regular practitioner patients; therefore, be it

Resolved, By unanimous vote, the Tulare County Medical Society presents the following resolution:

Resolved, That the Tulare County Medical Society protests the inclusion of osteopathic physicians and surgeons in any program sponsored by C.P.S.

Speaker Askey: The resolution is referred to Reference Committee Number 1, inasmuch as it refers to part of the Report of Doctor Chandler's Committee which was referred to Committee Number 1.

At this time I am going to give Dr. Goin the floor.

Dr. Goin: Mr. Speaker, thank you.

I speak now as an Administrative Member of C.P.S. Again, I have made an error. I named Dr. Robert S. Stone as Chairman of the Resolutions Committee, but he not being an Administrative Member of C.P.S. is not eligible to serve. In his place I should like to ask Dr. J. Marion Read to serve as a member of that Committee.

Dr. C. Max Anderson (Los Angeles):

Resolution Number 11:

Whereas, Dr. George Henry Kress, secretary of the California Medical Association and Editor of its Journal, California and Western Medicine, is laying down, at the close of this annual session, the burdens which he has carried so long and so faithfully, and

Whereas, Dr. Kress has served the medical profession of the County of Los Angeles and of the State of California for forty-two years as county secretary and president, as state president and secretary, as vice-president of the American Medical Association, as the able editor of the *Southern California Practitioner* and of California and Western Medicine, as a teacher and practitioner of medicine, as Dean of the Medical Department of the University of California, and in innumerable other positions, and

Whereas, In every capacity in which he has been called upon to serve, whether humble or exalted, he has done so with a full measure of devotion, enthusiasm and attention to duty which has rarely been equaled and never exceeded, all of which he has done with complete disregard for time, fatigue, and his own personal welfare through his great science and for those who seek to further it, his colleagues; therefore be it

Resolved, That this House of Delegates, representing the several thousand members of the California Medical Association, who, if present would heartily concur, do hereby express our deep affection for Doctor Kress, our admiration for his work and accomplishments, our deep gratitude for his lifetime of service to us, and our hope that he may enjoy many more years of good health in which to complete the historical work which he is undertaking for our Association; and, be it further

Resolved, That the Council be directed to prepare an appropriate plaque, bearing suitable sentiments, to be presented to Doctor Kress as a small token of our esteem, and that Doctor Kress be designated Editor Emeritus.

Vice-Speaker Alesen: The resolution will be referred to Reference Committee Number 3.

Speaker Askey: Dr. William L. Bender!

Dr. William Bender (San Francisco):

Resolution Number 12:

Whereas, Special services and skills are nearly adequately compensated in established fee schedules of most voluntary prepaid medical plans; and

Whereas, It is universally agreed that fees paid under similar plans to internists for special services are wholly inadequate; and

Whereas, Increasing numbers of people are and will be receiving medical care under such plans, and

Whereas, The net effect of these factors has become a critical problem recognized by the California Society of Internal Medicine; now, therefore be it

Resolved, That the House of Delegates of the California Medical Association approve the principle that charges for such special services of internists shall be increased to a level already apportioned to physicians in other specialties.

Speaker Askey: It will be referred to Reference Committee Number 3. Dr. Bruck!

Dr. Edwin L. Bruck (San Francisco): I have two resolutions to present, Mr. Speaker. As to the first one, I would like to lay a little background if I may.

The committee from a conference between the Pharmacists of California and representatives of the American Pharmaceutical Association regarding an order which has just come out from the Commissioner of Food and Drugs, Federal Security Agency, learned that this order would make it mandatory for the prescription package to carry on its label that which would designate the amount and names of the various ingredients of the prescription which would be given to the patient and then he is given the prescription to take on home and take the medication.

The Pharmacists feel that this is a great danger and in the conference with these gentlemen today the committee appointed by the Council drafted the following resolution.

Resolution Number 13:

Whereas, The Commissioner of the Foods and Drugs Division of the Federal Security Agency has recently issued order TC 6 A which provides that drugs and/or pharmaceutical preparations which carry a warning label on the manufacturers package, must have this same warning label affixed to the package dispersed by the pharmacist on prescription of a licensed physician; and

Whereas, The fixing of such a warning label on the package prescribed by the physician and dispersed by the pharmacist will cause suspicion and distrust by the patient of both the physician and the pharmacist; and

Whereas, Such loss of confidence on the part of the patient will generally destroy in whole or in part the value of the treatment prescribed, and

Whereas, The physician by training and knowledge is capable of correctly prescribing drugs even though they may have such a manufacturers warning label attached to them; therefore be it

Resolved, That the House of Delegates of the C.M.A. communicate with the Commission of Drugs of the Food and Drug Administration, protesting this action and requesting that ruling TC 6 A be withdrawn; and be it

Further Resolved, That our representative in Washington, D. C., be requested to urge the withdrawal of order TC 6 A; and be it

Further Resolved, That a copy of this resolution be forwarded to the American Pharmaceutical Association, with the request that they too continue to urge the withdrawal of order TC 6 A.

Speaker Askey: It will be referred to Reference Committee Number 3.

Dr. Bruck: The second resolution, I believe, I hardly have to read.

Resolution Number 14:

Whereas, The activities of the editor of the A.M.A. have created in the minds of the public and members of Congress the impression that he is the official spokesman for American Medicine and the A.M.A.; and

Whereas, The activities of the editor have been detrimental rather than beneficial in the field of public relations and efforts to safeguard the medical profession from dangerous and destructive legislation; now, therefore, be it

Resolved, That the members of the House of Delegates of the A.M.A. from the C.M.A. be directed to introduce and strive for the passage of the following resolution.

Resolved, That the Board of Trustees of the American Medical Association be directed by the House of Delegates of the American Medical Association to restrict the activities of the editor solely to those of editor; and, be it

Further Resolved, That the Trustees be requested to require that the editor refrain from appearing in public and at legislative hearings as a representative of the American Medical Association; and, be it

Further Resolved, That the Board of Trustees require that the editor devote his entire time to the publications of the American Medical Association and not engage in outside employment or activities for personal financial gain. (Applause.)

Speaker Askey: That will be referred to Reference Committee Number 3.

Dr. C. Kelly Canelo (Santa Clara County): I have the following resolution to present.

Resolution Number 15:

Be It Resolved, That Members of the California Medical Association shall not become or remain associated or identified with any corporation, organization, group, or individual, medical or lay, which either

(1) Resorts to or makes use of direct advertising to the public for business of a medical or therapeutic nature, or

(2) Engages directly or indirectly in or is in any manner connected with the diagnosis, care or treatment of the sick or injured, the maintenance of health or the prevention of disease, unless such corporation, organization, group or individual, and the terms of such association have been approved by action of the council of the California Medical Association. The council in determining the propriety of such association shall apply the principles of medical ethics as laid down by the California Medical Association and American Medical Association.

Speaker Askey: It will be referred to Reference Committee Number 3.

Dr. Charles Galligan (Monterey County):

Resolution Number 16:

Whereas, There have been many cases of death in which coroners have signed the death certificate without sufficient information as to the cause of death; and

Whereas, Section 10400 of the Health and Safety Code of the State of California reads as follows:

The Medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased except in the following cases:

(A) Where the attending physician is unable to state the cause of death.

(B) Where a person has been killed or has committed suicide.

(C) Where death is the result of an accident.

(D) Where an injury is a contributing cause of death.

(E) Where the death occurred under such circumstances to afford a reasonable ground to suspect that it was caused by the criminal act of another, and

Whereas, Section 10425 of the Health and Safety Code specifies the duties of the coroner reads as follows:

The certificate of death shall be made by the coroner in case of any death occurring under any of the following circumstances:

(A) Without medical attendance.

(B) During the continued absence of the attending physician.

(C) Where the attending physician is unable to state the cause of death.

(D) Where the deceased person was killed or committed suicide.

(E) Where the deceased person died as the result of an accident.

(F) Under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another; and

WHEREAS, No place in the Health and Safety Code, including section 10425 to 10429, does it specifically direct the coroner to perform an autopsy, if the physician is unable to sign the death certificate and coroners many times have been loath to order autopsy in such cases which did not appear to have involved any criminal action, and

WHEREAS, Coroners feel that in doing such autopsies without specific authorization in the law, they may be liable for suit; and

WHEREAS, This practice gives false information in vital statistics and does not improve and assist in the development of better medical practice; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association in session instruct its legislative committee to introduce legislation, amending the above mentioned sections of the California Health and Safety Code and in particular the duties mentioned in Section 10425 to make it mandatory that an autopsy be ordered by the coroner before said coroner makes such certificate under the provisions of this section and under the provisions of the above mentioned Section 10400, of the said code, wherein physicians are not to sign death certificates.

SPEAKER ASKEY: The resolution will be referred to Reference Committee Number 3.

DR. CHARLES GALLIGAN:

Resolution Number 17:

WHEREAS, The coroner system in the State of California has long been obsolete, unsatisfactory and inefficient; and

WHEREAS, Monterey County, as well as most of the other counties in the State, has had numerous difficulties in the prosecution of the law and the efficient compilation of vital statistics; and

WHEREAS, Proper coördination of coroner and the individual and collective doctors of medicine is impractical in many instances and impossible in others; and

WHEREAS, The California Medical Association is desirous of promoting the highest possible medical standards; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association in session, instruct its legislative committee to introduce, or cause to be introduced, legislation in the California State Legislature abolishing the coroner system and substituting in its place a medical examiner system in which the examiner must be a qualified doctor of medicine; be it

Further Resolved, That the legislative committee of the California Medical Association be instructed to re-introduce and continue to work for such legislation in each legislative session until the aims of the C.M.A. have been realized.

SPEAKER ASKEY: It will be referred to Reference Committee Number 3.

DR. DELL T. LUNDQUIST (Santa Clara County): There is one other perennial resolution. The last time it was presented I think it was probably the shortest resolution in the record. This time I have sketched in a little more of the background but I will try not to worry you too much. I have left out a lot of the "Whereases."

MEDICAL RELATIONS—RETROSPECT AND PROSPECT

A man with insight has pointed out in connection with the atomic bomb controversy that security of secrecy is weak as compared with security of achievement.

The proprietor in the successful creamery based on the "extra scoop of ice cream in the milk shake" was conducting a business based on the security of hard work which his less daring competitors found hard to meet. From the dawn of recorded history medicine has stood in the forefront of those striving for security of achievement. The earliest known written document (called by the name of Edwin Smith who bought it from the Egyptians) a papyrus copy made some 1800 B.C. from an original of perhaps 3000 B.C., deals amid an overlay of superstitution and incantation, with some sound scientific observations and insight. Even in those remote days of the pyramids was being laid the foundation structure of medicine's security of achievement.

However, as has always been the case in history, men have attempted to set up rules under which the game is to be played, although it is the spirit behind the rules and the men who play the game or seek to evade the rules that really matter. The Code of Hammurabi, imprinted on tablets of clay contained references to the "rules of the game" in the crude medical practice of its days. The Greek precepts attributed to Hippocrates and the Semitic prayer of Maimonides were steps toward the perfect light.

The commercialized practices of some of the early European "barber surgeons" and the secrecy surrounding the origin and exploitation of the obstetrical forceps are examples of what we can well avoid in medicine if we are to remain "above the common herd" as the beloved R.L.S. so fondly characterized the medical profession in general.

These preliminary remarks are intended as background to the story of the repeated efforts of this delegate to secure interest of the medical profession in recodifying the code of ethics, starting with the Santa Clara County Medical Society in 1935 and through it repeatedly to the State Society, and by direction of the latter even to the House of Delegates of the A.M.A.

Historically, the A.M.A. code of ethics is an admirable document. Its general principles are undying and adaptable to many diverse circumstances. However, the interpretation of it needs clarification.

Just a few examples:

1. *Press, Radio, Cinema, Television, Etc.:* What are the ethics of appearance of members of our profession under such circumstances as surround these modern methods of education and propaganda?

2. *Medical Copyright, Patents, Etc.:* Shall the tradition of no secrecy of remedies be restricted or extended? What of members of the profession under domination of commercial pharmacy? Is there one principle fostering copyright of medical ideas and another opposing patent of medical appliances and materials? Are universities and foundations above rules?

3. *Contract Practice:* Under what conditions is it allowable? The American College of Surgeons might well investigate the extent of fee splitting under the guise of contract and *group* practice.

4. *Alleged Malpractice and Other Legalities:* What are the rules down to date on appearance of "expert witnesses" in court?

What is etiquette in seeing a patient formerly treated by another physician?

These are just selected examples (a list might be extended) of points that need clarification and modernization. As Dr. Lowell S. Goin has pointed out, what we need is a case book, borrowing a principle from our legal friends. We, however, need to avoid the characterization often applied to that learned profession, namely interest only in the past and disinterest in the future. If we are to maintain the liberal tradition of freedom, and avoid entanglement in cartels and monopolies both private and governmental, we need to refresh our vision by looking to our illustrious past, face our not inconsequential mistakes as well, and turn toward a future which we hope will be bright.

Let us with due humility offer to the world, perhaps even internationally, an example of the free and open security of achievement—a middle road between the secrecy and totalitarianism of both cartels and communism in their struggle for exclusive domination.

Let us in our deliberations and external relations be an example of free covenants openly negotiated. May our collective bargaining not be "in restraint of trade," but in the truly liberal tradition.

So much for the "whereases":

Resolution Number 18:

Now, therefore, be it Resolved, That this Association reaffirm its previous action taken or rather words without action (taken on behest of this delegate) and instruct its appropriate officers to resurrect from the archives the previous reports and breathe the breath of life into a code on a statewide basis, even if the A.M.A. will not do so. Our largest two county societies have already made noteworthy steps toward meeting this need for themselves—but statewide action is urgent; and be it

Further Resolved, That the essence of this resolution again be offered to the House of Delegates of the A.M.A.

SPEAKER ASKEY: It will be referred to Reference Committee Number 3.

DR. RICHARD O. BULLIS (Los Angeles County):

Resolution Number 19:

WHEREAS, The rapid growth of the California Medical Association makes it increasingly difficult to secure adequate meeting places and hotel accommodations at annual sessions with the result that many members are discouraged from attending the annual sessions; and

WHEREAS, The presence of a maximum number of members is needed if fraternal relations between members and the best interests of scientific and organized medicine and of the public health are to be furthered to the utmost; therefore be it

Resolved, That the Council be instructed to consider the advisability of arranging regional scientific and economic meetings or conferences of perhaps two days duration, annually or semi-annually; and be it

Further Resolved, That the Council consider the advisability of having at such mid-year conferences a meeting of the president and secretaries of component county associations within the area of each regional conference, so that matters of organization and related problems of the profession may be considered.

SPEAKER ASKEY: It will be referred to Reference Committee Number 3.

Are there any further resolutions?

DR. WILBUR BAILEY (Los Angeles County): I have two resolutions.

Resolution Number 20:

WHEREAS, Plans are under consideration to pension or to make pension plans for members of the central office of the C.M.A., and whereas such plans are laudable and worthy in motive; but

WHEREAS, Such plans require the spending of monies which we as delegates have been elected to husband; and

WHEREAS, Considerable reduplication in the future may occur as Social Security benefits are expanded; and

WHEREAS, Probably none of us as individuals have pension plans for our employees; and

WHEREAS, To favor pension plans for the C.M.A. would, therefore, savor of the good old American custom of letting the Federal Government spend money which we would not ourselves spend, or to put it differently we would not be acting the same way as a group that we would as individuals; now, therefore, be it

Resolved, That the custom which the Securities and Exchange Commission requires of corporations be followed by the C.M.A.

i.e., if the pension plan or plans be favored by the House of Delegates, that such plans be further submitted in a referendum to the membership in order that a vote on each main problem may be cast by each member.

SPEAKER ASKEY: The resolution will be referred to Reference Committee Number 3.

DR. BAILEY: This is largely a matter of information.

Resolution Number 21:

WHEREAS, The chiropractors have recently made plans to spend thirty to fifty thousand dollars in the hope of passing an Initiative Measure entitled "Treatment of the Sick and Disabled," and whereas the Attorney General has summarized this initiative as follows:

"Permits treatment of the sick and disabled by system of naturopathy. System to include, among other methods, electrotherapy, herbs, glands, biochemistry, minor surgery, bone setting, and obstetrics. Creates board to license and regulate practice of, and add new methods to the system. Provides persons having previously practiced one or more branches of the system under license shall be licensed without examination. Provides those licensed to practice may use title 'Naturopathic Physician' or 'Doctor of Naturopathy,' or 'N.D.' Establishes educational requirements, subject to change by board. Provides penalties for practicing without license." and

WHEREAS, The literature is being circulated with these petitions for an initiative which reads as follows:

"THE NATUROPATHIC ACT"

"1. Establishes new and stricter standards for the treatment of the sick and disabled in California.

"2. Is specifically designed for the care, treatment and rehabilitation of returning war veterans.

"3. It requires more educational and medical training as follows:

"(a) Graduation from high school.

"(b) One college year of physics, chemistry, biology and zoölogy.

"(c) Four years study and graduation from Naturopathic School.

"4. Establishes a state board to examine, license, control, regulate and discipline all physicians practicing under the Act.

"Examples of naturopathy treatments:

"(1) The Sister Kenny method of treating infantile paralysis by hydrotherapy and exercise.

"(2) Electrotherapy, herbs, chiropractic, etc.

"5. Present state laws permit chiropractors and osteopaths to deliver babies and perform other minor surgery (example—lancing boils, binding cuts).

"The Naturopathic Act gives the state stronger control over such matters and sets up higher medical standards.

"The Act is endorsed by war veterans and union workers.

"The Act here proposed is based on the Naturopathic Act of the District of Columbia, enacted by the Congress of the United States, which enacts all the laws for the District of Columbia"; and

WHEREAS, No thinking person would be led astray by such reasoning, but others might be, now, therefore, be it

Resolved, That the C.M.A. and its affiliates make every effort to acquaint the public at the appropriate time of the actual nature of these attempts to sabotage the present standards of medical practice.

(Applause.)

SPEAKER ASKEY: It will be referred to Reference Committee Number 3.

I understand petitions are now on the street.

Are there any further resolutions? Remember, this is the last chance you will have to introduce a resolution into this House without unanimous consent of the House. If you have a resolution for this session of the House it must be introduced tonight without fail.

DR. J. FRANK DOUGHTY (San Joaquin County):

Resolution Number 22:

WHEREAS, Many government agencies do business with the medical profession, and

WHEREAS, Such agencies establish their own fee schedules without any correlation or consideration, therefore be it

Resolved, That a comprehensive fee schedule be drawn up by the committee of the C.M.A., appointed by the Council, and such schedule for services be established for dealing with all government agencies.

SPEAKER ASKEY: It will be referred to Reference Committee Number 3. Are there any further resolutions to be placed before this House? I don't want to close anybody off now. If you have resolutions, now is the time. If not, Dr. Dwight Murray has asked for the floor. Dr. Murray!

DR. DWIGHT MURRAY: Mr. Speaker, Members of the House of Delegates: There was a certain election of the House of Delegates of the California Medical Association and as the result of that election, I should say, it is necessary for me to tender my resignation as a Delegate to the A.M.A. I do so, Mr. Speaker, with regret.

SPEAKER ASKEY: Dr. Murray, the Speaker would like to explain the reason for that. Dr. Murray, was last year, as you remember, elected Trustee of the American Medical Association. To a great many of us and all of you, I am sure, that was a wonderful thing because we know what Dr. Murray has done for medicine. We know that with a man of this character and type on the Board of Trustees of the American Medical Association that we are standing in quite a good position. By reason of the fact that he is a Trustee he is a member of the House of Delegates of the American Medical Association and, therefore, by his resignation as your Delegate we may elect another one and have two there instead. So a motion to accept Dr. Murray's resignation as of this date will be in order which will allow us at the next session Thursday night to elect a successor. Do I hear such a motion?

Dr. Kenneth D. Gardner (San Francisco): I so move.

Dr. Moody: I will second the motion.

Speaker Askey: Is there any discussion on the motion? If not, all in favor of the acceptance of the resignation of Dr. Murray as Delegate to the American Medical Association say "aye"; opposed "no."

. . . The motion was put to a vote and it was unanimously carried. . . .

Speaker Askey: It is carried. Your resignation is accepted. Your position is open for filling at the next session of the House.

At this time I would like to have a motion made that the President, the Secretary and the Speaker, be appointed a committee to edit and prepare the Minutes of this session. Do I hear such a motion?

Dr. Bruck: I so move.

Dr. Dewey: I will second the motion.

. . . There being no discussion on the motion, the motion was put to a vote and it was unanimously carried. . . .

Speaker Askey: Is there any further business to come before this House?

If not, an adjournment will be in order to adjourn to 3:30 Thursday.

The Secretary calls attention to the fact that all members of the Reference Committees will please meet at this table immediately after the adjournment of this session of the House. I think you all have the numbers of the rooms in which the committees will meet. They will be on the bulletin board and if you wish to find them, you will find them there. We want you to appear at these meetings and it is your duty to so appear.

Is there a motion to adjourn this meeting? The next meeting will be at 3:30 Thursday afternoon.

Dr. McClendon: I so move.

Dr. Kneeshaw: I will second the motion.

. . . The motion was put to a vote and it was unanimously carried. . . .

Speaker Askey: We are adjourned.

. . . The session adjourned at 9:45 P.M. . . .

Second Meeting of the C.M.A. House of Delegates Thursday Afternoon, May 9, 1946

The Second Meeting of the House of Delegates of the California Medical Association, Seventy-fifth Annual Session of the Association and Forty-third Annual Session of the House of Delegates was held in the Music Room of the Biltmore Hotel, Los Angeles, California, May 9, 1946. The meeting was called to order at 3:40 P.M. by Dr. E. Vincent Askey, Speaker of the House of Delegates.

Speaker Askey: The House will be in order, please. Will the Delegates please take their seats? We wish to start as we have a lot of business to attend to today. The Chair will again call attention to the fact that we wish Delegates to be seated ahead of the middle aisle. Those who are not regularly seated as Delegates will please sit back of the aisle. The reason is not that we don't want you handsome fellows up here, but the Chair will become befuddled sometime in a vote if I attempt to pick out those that are entitled to vote and those that are not, so the Delegates who are to be seated will please sit in front of the middle aisle and the others in the back.

At this time the Speaker will recognize the Chairman of the Credentials Committee to see if there is a quorum present. Dr. DeLos Reyes.

Dr. DeLos Reyes: Mr. Speaker, I have in my hand the credentials of seventy-five members of the Convention and that constitutes a quorum.

Speaker Askey: Thank you, Doctor. The Chairman of the Committee reports a quorum present. The House will be in session.

At this time we will have the roll call and in order to seat all the Delegates, will the Secretaries proceed with the roll call and the Speaker will call attention again to the procedure of this House. That is that each Delegate, when the roll of Delegates will be called, if there is an unfilled seat by the absence of any Delegate, then the roll of Alternates will be called and the Alternates may be seated in a specific Delegate's seat. If there are insufficient Alternates present and there are still vacancies, the members of that county may be seated with the concurrence of the House or any empty or absent Delegate or Alternate. I hope you understand it, if not, questions will be in order.

Dr. Kress, will you call the roll?

Roll Call

. . . During the calling of the Roll, the Vice-Speaker assumed the chair. . . .

Vice-Speaker Alesen: If there are any changes they can be made later on and this will constitute the House of Delegates. The Speaker now declares the House to be convened, and in session.

. . . Speaker Askey assumed the Chair. . . .

Speaker Askey: Thank you, Mr. Vice-Speaker.

At this time the Secretary wishes to make an announcement in regard to the Council's recommendation for the annual 1947 session.

Secretary Kress: Mr. Speaker, you may announce the matter is suspended for further consideration.

Speaker Askey: The Speaker recognizes Dr. Kress who states that the Council has recommended that it be taken up at a future time because as yet we have not been able to find a place to meet. You will be notified by the Council at a very early date, as soon as arrangements can be made in regard to the 1947 session.

Election of Officers

Speaker Askey: The next regular order of business is the Election of our officers for the next year.

Election of Present-Elect

Dr. L. R. Chandler: I would like to place in nomination for *President-Elect,* Dr. John Cline of San Francisco.

I don't know anyone that I would rather see receive the recognition of the medical profession by making that person their President, or President-elect than Dr. Cline. Most of you know him personally. He has devoted himself enthusiastically without prejudice or bias and he wears no man's collar, for the good of the medical profession. He has served two terms as Councilor. He has the confidence and support of everyone that has worked with him and this is a unanimous nomination from the Delegation from San Francisco. Thank you very much. (Applause.)

Speaker Askey: Dr. Cline of San Francisco has been nominated as President-elect. Are there other nominations?

A Member: I move the nominations be closed and that the Secretary be instructed to cast a unanimous ballot for Dr. Cline.

. . . The motion was seconded. . . .

Speaker Askey: Such a motion requires unanimous consent. I hear no more nominations, so we will vote on the motion.

. . . A vote was taken on the motion and it was unanimously carried. . . .

Speaker Askey: Dr. Cline is elected your President-elect. Dr. Cline! (Applause.)

The next office is that of your *Speaker*. Are there nominations for the office of *Speaker of the House of Delegates?*

Dr. T. D. Caruso (Los Angeles): Mr. Speaker, Members of the House of Delegates: I am sure that the man whom I will propose as Speaker of the House of Delegates requires no introduction. At this time I would like to propose Dr. E. Vincent Askey to succeed himself as Speaker of the House of Delegates of the California Medical Association. (Applause.)

Vice-Speaker Alesen: Dr. E. Vincent Askey has been nominated to succeed himself as Speaker of the House of Delegates. Are there any further nominations?

A Member: I move that the nominations be closed.

. . . The motion was seconded. . . .

Vice-Speaker Alesen: Have you had ample opportunity to make nominations? If so, it has been moved and seconded that the nominations be closed, and that the Secretary cast a unanimous ballot in favor of E. Vincent Askey.

. . . A vote was taken on the motion and it was unanimously carried. . . .

. . . Speaker Askey assumed the Chair . . .

Speaker Askey: I appreciate that very much.

The reason I stood up here was that I knew pretty well you were going to nominate me. It looks very well for a speaker to sit down and expect it if you are going to nominate anyone else, and I am man enough to take it. I appreciate it.

Speaker Askey: The next office to be filled is that of *Vice-Speaker of the House of Delegates*. Dr. Crane!

Dr. J. J. Crane (Los Angeles): I wish to place the name of Louis A. Alesen in nomination for the office of Vice-Speaker to succeed himself.

Speaker Askey: The name of Dr. Lewis Alesen is in nomination.

A Member: I move the nominations be closed.

. . . The motion was seconded. . . .

Speaker Askey: You have heard the nomination. Are there further nominations?

. . . The motion was put to a vote; it was carried and the Secretary cast a unanimous ballot for Vice-Speaker Alesen. . . .

Speaker Askey: It is unanimous and so ordered. Dr. Alesen! (Applause.)

Speaker Askey: The next order of business is the election of *District Councilors*. For your information your Speaker will again call attention to the C.M.A. By-Laws by which means District Councilors are nominated. They must be nominated by written nomination by the Delegates from the District involved, and if only one nomination is made, by a majority of the votes of the House, it may either be sustained or denied. If there is more than one nomination presented a majority vote is required for election. If there are three or more and nobody receives a majority, the one receiving the least number of votes shall be dropped and the other names voted upon until a majority is present.

Are you ready for the election of District Councilors?

The first is that of the Third District, Harry E. Henderson.

Mr. Secretary, do you have nominations from that District?

Secretary Kress: In accordance with the By-Laws, nominations for the *Third District Councilor* have been submitted as follows: A nomination by the counties of Santa Barbara and Ventura for Dr. Harry E. Henderson of Santa Barbara; a nomination by San Luis Obispo County Delegates for Frederick R. Mugler, these are the only two nominations for the Third District.

Dr. Remmen: At this time I request a fifteen minute recess in order that the Los Angeles delegation may caucus.

Speaker Askey: It has been the custom of this House to grant a recess privilege to a caucus for any reasonable length of time. I think fifteen minutes is a reasonable time. If there is no objection your Speaker will declare a recess for the purpose of caucus only. I hear no objection—the recess is granted.

. . . The House was recessed from 4:10 P.M. to 4:25 P.M. . . .

Speaker Askey: The delegates will resume their seats as quickly as possible. We must get through with our duties because we don't want to stay too late tonight. To save a little time, while you are taking your seats, the Speaker wishes to announce the Tellers Committee for all elections held in this session. The committee will consist of Tellers as follows: Dr. Lundquist, Dr. Madeley, Dr. Roos, of Riverside.

Dr. Lundquist will be Chairman of the Tellers Committee.

In case there is a necessity for Executive Session Procedure, we will appoint a Sergeant-at-Arms in the person of Dr. Eugene F. Hoffman of Los Angeles. Dr. Hoffman will be Sergeant-at-Arms of this session.

The election is now before you. The names of the nominees, which are the only nominees officially made, are Dr. Frederick R. Mugler and Dr. Harry E. Henderson. This is for District Councilor of the Third District, the term of Harry E. Henderson expiring. The Tellers will please pass the ballots between you. You are to vote for one or the other of these men. In order that there will be no mixup such as we had a year or two ago, the ballots will be of a different color. The ballot for this election is of a white color.

. . . Voting by the delegates. . . .

Speaker Askey: If the votes have been collected we will go ahead with further nominations in order to save a little time. Are your ballots all in? Is there anybody who hasn't voted who wishes to vote? If not, the ballot is closed.

The next is for Councilor from the Sixth District. Are there any written nominations?

Dr. Kress: The delegates from the *Sixth District* have placed in nomination the name of Edwin L. Bruck. There is also on file, Mr. Speaker, the resignation of Edwin Bruck as a Councilor-at-Large.

Speaker Askey: That is the only nomination that was made by the delegates. For the purpose of explaining to the House, Dr. Bruck has been a Councilor-at-Large. It has been decided by his own district that he be their District Councilor rather than a Councilor-at-Large. For that reason, as the Secretary stated, the resignation of Dr. Bruck as Councilor-at-Large is to take effect immediately. Is there a motion to accept that resignation?

. . . . It was so moved and seconded. . . .

Speaker Askey: Is there discussion?

. . . There being no discussion, the motion was put to a vote and carried. . . .

Speaker Askey: He is now no longer Councilor-at-Large. A nomination is thereby made by his District, the San Francisco Medical Society, of Dr. Edwin L. Bruck for the District Councilor, that being the only nomination. It is your privilege to either sustain or reject this nomination. If you wish to sustain it, it must be by a majority vote.

A Member: I move we sustain it.

Speaker Askey: The By-Laws state that all elections must be by ballot unless there is a motion that this rule be rescinded. It must be carried by a two-thirds vote. Is there such a motion, that we vote by acclamation?

. . . It was moved, seconded and carried, that this election be by acclamation, it receiving a two-thirds vote. . . .

Speaker Askey: It is carried. The question now goes before you as to the sustaining or rejecting of the name of Edwin L. Bruck. All those in favor of sustaining the nomination and electing Dr. Bruck please stand.

. . . Rising vote. . . .

Speaker Askey: It is carried unanimously. The nomination is sustained and Dr. Bruck is elected. (Applause.)

The next is the election of the *Councilor from the Ninth District* for the term of John W. Green, expiring. Are there written nominations from the Ninth District, Mr. Secretary?

Dr. Kress: Mr. Speaker, the Delegates from the Ninth District have nominated John W. Green of Vallejo.

Speaker Askey: The name of Dr. John W. Green to succeed himself has been put in nomination. There being no further nominations the same procedure is in order. Do I hear a motion that the vote be changed from that of ballot to acclamation?

Dr. Anderson: I so move.

Speaker Askey: Is there a discussion? This will require a two-thirds vote.

. . . There being no discussion, the motion was put to a vote and was unanimously carried. . . .

Speaker Askey: The vote will be by acclamation. All those in favor of sustaining the nomination and electing John W. Green say "aye"; opposed "no."

. . . The motion was put to a vote and it was unanimously carried. . . .

Speaker Askey: The nomination is sustained and he is elected. (Applause.)

Speaker Askey: The next is the election of *Councilors-at-Large*. There will be three vacancies to be filled. The first is that of Dewey R. Powell, term expiring, of Stockton. Now each of these nominations are not by writing, but are by nomination from the floor and it will be in order to receive nominations for each separate office which must be voted on one at a time, and then the others will wait until that office has been filled; in other words, you are voting for each separate office. The first Councilor-at-Large, that one being held by Dewey R. Powell, his term expiring. Are there nominations?

Dr. R. L. Owens (San Joaquin County): I would like to place the name of a general practitioner who has served in the war for the past five years, Dr. C. V. Thompson of Lodi.

Speaker Askey: You have heard the nomination, are there further nominations for this office?

A Member: I move the nominations be closed.

Dr. Doughty: I will second the motion.

Speaker Askey: Is there any further desire for nominations; if not, all those in favor of closing the nominations and casting the votes for Dr. Thompson say "aye"; opposed "no."

. . . A vote was taken on the motion and it was unanimously carried. . . .

Speaker Askey: It is unanimously carried and he is declared elected.

The next is for the office of Councilor-at-Large, for the office held by Edward B. Dewey of Pasadena, term expiring. Are there nominations for that office?

Dr. Edward Dewey (Pasadena): Members of the House of Delegates: Just to make sure in offering this nomination that no one thinks that I am trying to choose the candidate, I want to say that I had nothing whatever to do with the choice of the candidates. I am, however, very happy and pleased to offer the man I want to nominate as a man who has devoted a great deal of his time and energy to the welfare of the doctors of Southern California, particularly along the line of malpractice and medical defense. He is at the present time President of the Los Angeles County Medical Society. I take great pleasure in nominating Dr. Louis J. Regan.

Speaker Askey: You have heard the nomination. Are there further nominations for this office?

Dr. Remmen: I move the nominations be closed.

Dr. Green: I second the motion.

. . . The motion was put to a vote and it was unanimously carried. . . .

Speaker Askey: It is unanimous, therefore, carried, and Dr. Regan is elected as Councilor-at-Large. (Applause.)

The third Councilor-at-Large is for the term of Dr. Edwin L. Bruck, resigned, for the unexpired term which will expire in 1948. Are there nominations?

Dr. Cline: It gives me great pleasure to place in nomination for this office Dr. H. Gordon MacLean of Oakland. He is Past-President of the Alameda County Medical Association; a President for some years of the Hospital Service of California, and a Delegate to the American Medical Association from this Association and a splendid man in medicine. (Applause.)

Speaker Askey: You have heard the nomination. Are there further nominations for this office?

Dr. Chandler: I move the nominations be closed.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

Speaker Askey: It is unanimous and, therefore, carried. I hereby declare Dr. MacLean elected to the unexpired term of Dr. Bruck.

The ballots are now counted for the election of the Third District. I hereby recognize Dr. Lundquist, Chairman of the Tellers, to report on the votes, please.

Dr. Lundquist: Mr. Speaker, we have counted the ballots. There were 178 ballots, one ballot for "Anderson," who was not in nomination, and 165 for Henderson and 12 for Mugler.

Speaker Askey: You have heard the votes. Dr. Henderson is reëlected for District Councilor of the Third District.

Speaker Askey: At this time we come to the election of Delegates to the American Medical Association. The election on this differs a little bit from all other elections. On this election a majority vote is not necessary. The man receiving the highest number of votes, if there are one or more nominated, is declared elected.

At this time I will ask Dr. Alesen, the Vice-Speaker, to take the chair.

. . . The Vice-Speaker assumed the chair. . . .

Vice-Speaker Alesen: Nominations are now in order for the election of delegates to the American Medical Association. The first incumbent is that of H. Gordon MacLean, term expiring. Nominations are in order.

Dr. William G. Donald (Alameda County): I would like to place in nomination to succeed himself, H. Gordon MacLean. It is foolish to repeat Dr. Cline's eulogy. In this time when prepaid medical care is spreading, a man with Dr. MacLean's experience in hospital insurance and his devotion to the cause of prepaid medical and hospital care is something we cannot afford to lose. I place in nomination Dr. H. Gordon MacLean. (Applause.)

Vice-Speaker Alesen: Dr. MacLean has been nominated to succeed himself. Are there any other nominations?

A Member: I move that the nominations be closed and that the Secretary cast a unanimous ballot for Dr. MacLean.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

Vice-Speaker Alesen: It is carried and so ordered. Dr. MacLean is elected.

The next Delegate is Dr. E. Vincent Askey, term expiring. Nominations are in order. Dr. Remmen!

Dr. Remmen: It gives me very great pleasure to place in nomination to succeed himself our very able Speaker, Dr. Askey. I am sure that he needs no further eulogy. (Applause.)

Vice-Speaker Alesen: Dr. Askey has been nominated to succeed himself.

. . . It was moved, seconded and carried that the nominations be closed. . . .

Vice-Speaker Alesen: It is carried and so ordered. Dr. Askey has been elected to succeed himself.

The next vacancy occurring is that of Dr. John W. Cline of San Francisco.

Dr. Carr: The San Francisco Delegation feels that there is a definite virtue in sequence, particularly in representation to the American Medical Association. We want to nominate Dr. John W. Cline to succeed himself.

Vice-Speaker Alesen: Dr. Cline has been nominated to succeed himself. Are there other nominations?

. . . It was moved, seconded and carried that the nominations be closed. . . .

Vice-Speaker Alesen: It is carried and so ordered. Dr. Cline is elected to succeed himself.

The next is Dr. Donald Cass, term expiring.

Dr. Hoffman (Los Angeles): Mr. Speaker and Delegates: It is the desire of the Los Angeles Delegation that we renominate to succeed himself Dr. Donald Cass.

Vice-Speaker Alesen: Dr. Donald Cass has been nominated to succeed himself. Are there other nominations?

. . . It was moved, seconded and carried that the nominations be closed. . . .

Vice-Speaker Alesen: Dr. Cass has been elected to succeed himself.

Now, we have the term held by Dwight H. Murray of Napa, 1946-1947, resigning because he is Trustee of the American Medical Association. Nominations are in order for this office.

Dr. H. Randall Madeley (Vallejo): To me, that is one of the most important offices. I think California has probably had the most outstanding delegation there has been to the A.M.A. for a number of years. I am sure they certainly made themselves known in the last session. One of our very prominent members of that Delegation has been sort of hiked upstairs. It gives me a great deal of pleasure to nominate Dr. Green. He served as alternate to Dr. Murray last year. Dr. Green was a member of the House of Delegates one term of some years, and has been Councilor for the last two years. His Councilor District has recently nominated him to the position for the next two years. I believe he is a definite asset to the A.M.A. from California.

Vice-Speaker Alesen: Dr. Green has been nominated.

Dr. Murray: Mr. Speaker, Members of the House of Delegates: I can't resist the temptation to put in a word for my old friend Pete. We have been friends now for over thirty years. He hasn't recently become interested in medicine. Ever since he came to California in 1921, and before coming to California, he has shown the greatest interest always in organized medicine. I have never known any task to be asked of him that was too big or too small for him to attempt. He nominated me one time and in so doing he said he wanted to send me back to Chicago wearing the shoes of June Harris and the coat of Henry Rogers, whose place I was elected to take.

It is with great pleasure that I now transfer to Dr. Green the shoes of June Harris and the coat of Henry Rogers, and may he wear them well. I know he will.

Vice-Speaker Alesen: Are there any further nominations?

. . . It was moved, seconded and carried that the nominations be closed. . . .

Vice-Speaker Alesen: It is carried. Dr. Green is elected. (Applause.)

Now we come to the subject of Alternates to the American Medical Association, Leopold H. Fraser, Richmond, Alternate to H. Gordon MacLean. Nominations are now in order. Are there any nominations?

(No response.)

What do you wish to do with the post of Dr. Leopold H. Fraser? Are you going to let this go by default?

Dr. Gleason (Alameda County): I move that Dr. Fraser be nominated to succeed himself.

Vice-Speaker Alesen: Dr. Fraser has been nominated to succeed himself. Are there further nominations?

. . . It was moved and seconded that nominations be closed. . . .

. . . The motion was put to a vote and it was unanimously carried. . . .

Vice-Speaker Alesen: It is carried and so ordered. Dr. Fraser has been elected.

The next is that of Dr. Donald G. Tollefson of Los Angeles, Alternate to Dr. E. Vincent Askey.

Dr. Peter Blong (Los Angeles County): I place in nomination the name of William Benbow Thompson of Los Angeles, Alternate to Dr. Askey.

Vice-Speaker Alesen: Dr. William Benbow Thompson has been nominated. Are there any further nominations?

. . . It was moved, seconded and carried that the nominations be closed. . . .

Vice-Speaker Alesen: The motion is carried and Dr. Thompson is elected.

The next is the term of Dr. C. Kelly Canelo, Alternate to John W. Cline.

Dr. John Hunt Shephard (Santa Clara County): Dr. C. Kelly Canelo has served us all well. I wish to place in nomination the name of Dr. C. Kelly Canelo to succeed himself.

Vice-Speaker Alesen: Dr. C. Kelly Canelo has been nominated to succeed himself. Are there further nominations?

. . . It was moved, seconded and carried that the nominations be closed.

Vice-Speaker Alesen: It is carried and so ordered.

The term of Ralph B. Eusden of Long Beach, Alternate to Dr. Donald Cass, is next in order.

Dr. Donald Cass: Fellow Delegates: I wish to place the name of Ralph Eusden in nomination to succeed himself as my Alternate.

. . . The motion was seconded. . . .

Vice-Speaker Alesen: Dr. Eusden has been nominated to succeed himself as alternate to the American Medical Association. Are there any further nominations?

. . . There being no further nominations, the motion was put to a vote and it was unanimously carried. . . .

Vice-Speaker Alesen: It is carried and so ordered.

. . . Speaker Askey assumed the Chair. . . .

Speaker Askey: Dr. Green was Alternate to Dr. Murray, and has been elected to succeed Dr. Murray. That leaves an alternate to be elected to Dr. Green for the term expiring.

Dr. Wilson Stegeman (Sonoma County): Sonoma County is very glad to place in nomination the name of Dr. Madeley. Dr. Madeley has been an able trustee of C.P.S. He has served the Legislative Committee of C.M.A. and he is an able practitioner. Furthermore, he is a nephew of Dr. Green and there is nothing like keeping it in the family.

Speaker Askey: There has been placed in nomination the name of Dr. Madeley as Alternate to Dr. Green, as Delegate to the American Medical Association. Are there further nominations?

. . . It was moved, seconded and carried that the nominations be closed. . . .

Speaker Askey: It is unanimous and therefore carried. Dr. Madeley is elected.

That concludes the election of officers.

At this time your Speaker wishes to introduce a man, if he is here, and if not, I will introduce him tonight. I don't know how many of you remember the election of the Vice-President of the American Medical Association last December in Chicago. One of your Past-Presidents, Dr. William R. Molony, was elected. Dr. Molony is Vice-President of the American Medical Association. Is he in the house? I wish he would come forward to this stand.

. . . Dr. Molony came to the front of the room. . . .

Dr. Molony, we welcome you as our Vice-President of the American Medical Association and one of the Past Presidents of this Association. We wish to introduce you to this Association. (Applause.)

Dr. William Molony: Mr. Speaker, and Brother Members of the California Medical Association: I am taken rather by surprise. I just came into the room and it is rather unusual for me to be introduced to the members of the California Medical Association, but I suppose that is the way they do it in a formal way. I am very, very happy to be here with you, to receive this recognition from you. It is, of course, as you must know, a rather complete surprise to me the signal honor that has come to me at this particular time, but it did, and of course I am very happy for myself and I am happy for all of the men in California, because in a sense, an office of that kind is a recognition not to the member only, but to the State it comes from. So I thank you very much indeed.

Speaker Askeys Will you sit at our table, Dr. Molony, and give us your presence. We would be very happy to have you sit with us.

Appointments to Fill Committee Vacancies

Speaker Askey: The next order of business is the announcement by the Secretary of the Council's nomination of members of the Standing Committee which must be approved by this House of Delegates. Dr. Kress!

Secretary Kress: Mr. Speaker and Members of the House: The new appointees recommended by the Council's Committee on Standing Committees and the Editorial Board, to fill unexpired terms ending in 1949 are indicated in the following roster:

Committee on Associated Societies and Technical Groups

Anthony B. Diepenbrock (Chairman)	San Francisco	1947
Edward F. Nippert	Los Angeles	1948
Peter Blong	Alhambra	1949

Committee on Health and Public Instruction

E. Earl Moody	Los Angeles	1947
C. M. Burchfiel	San Jose	1948
George M. Uhl (Chairman)	Los Angeles	1949

Committee on History and Obituaries

Morton R. Gibbons, Sr. (Chairman)	San Francisco	1947
Robert A. Peers	Colfax	1948
E. T. Remmen	Glendale	1949
George H. Kress (Honorary Historian)	ex-officio	

Committee on Hospitals, Dispensaries and Clinics

Roy E. Thomas	Los Angeles	1947
Clarence E. Rees (Chairman)	San Diego	1948
Anthony J. J. Rourke	San Francisco	1949

Committee on Industrial Practice

N. P. Dunne	Oakland	1947
Donald Cass (Chairman)	Los Angeles	1948
J. B. Josephson	San Jose	1949

Committee on Medical Defense

Nelson J. Howard	San Francisco	1947
William A. Key (Chairman)	San Mateo	1948
Louis J. Regan	Los Angeles	1949

Committee on Medical Economics

Wayne J. Pollock	Sacramento	1947
H. Gordon MacLean (Chairman)	Oakland	1948
Howard W. Bosworth	Los Angeles	1949

Committee on Medical Education and Medical Institutions

B. O. Raulston (Chairman)	Los Angeles	1947
L. R. Chandler	San Francisco	1948
Francis Scott Smyth	San Francisco	1949

Committee on Organization and Membership

Carl L. Mulfinger (Chairman)	Los Angeles	1947
Harold G. Trimble	Oakland	1948
Henry A. Randel	Fresno	1949

Committee on Postgraduate Activities

H. F. Friedell	Santa Barbara	1947
John C. Ruddock (Chairman)	Los Angeles	1948
Salvatore P. Lucia	San Francisco	1949
L. Henry Garland	ex-officio	

Committee on Publications

F. Burton Jones	Vallejo	1947
R. H. Sundberg	San Diego	1948
George W. Walker (Chairman)	Fresno	1949
L. Henry Garland	ex-officio	
Dwight L. Wilbur	ex-officio	

Committee on Public Policy and Legislation

Dwight H. Murray (Chairman)	Napa	1947
Lloyd E. Kindall	Oakland	1948
E. T. Remmen	Glendale	1949
Association President	ex-officio	
Association President-Elect	ex-officio	

Advisory Committee

Junius B. Harris (Chairman)	Sacramento
H. R. Madeley (Vice-Chairman)	Vallejo
Wilson Stegeman	Santa Rosa

Committee on Scientific Work

L. Henry Garland (Chairman)	ex-officio	
J. Homer Woolsey	Woodland	1947
Howard F. West	Los Angeles	1948
Clayton Mote	San Francisco	1949
A. Morse Bowles	(ex officio, Sec'y, Section on Medicine)	
Howard O. Dennis	(ex officio, Sec'y, Section on Surgery)	

Cancer Commission

George Sharp	Pasadena	1947
Whitfield Crane (Vice-Chairman)	Oakland	1947
Gertrude Moore	Oakland	1947
Henry J. Ullmann	Santa Barbara	1948
David A. Wood (Sec'y, Northern California)	San Francisco	1948
James F. Rinehart	San Francisco	1948
Lyell C. Kinney (Chairman)	San Diego	1949
L. Henry Garland	San Francisco	1949
Orville N. Meland (Sec'y, Southern California)	Los Angeles	1949

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Editorial Board

For the Editorial Board, to serve during the coming year, the following group of members:

Chairman of the Board:
Dwight L. Wilbur, San Francisco
Executive Committee:
Lambert B. Coblentz, San Francisco
Albert J. Scholl, Los Angeles
H. J. Templeton, Oakland
Dwight L. Wilbur, San Francisco
Anesthesiology:
William B. Neff, San Francisco
Charles McCusky, Los Angeles
Dermatology and Syphilology:
Paul Foster, Los Angeles
H. J. Templeton, Oakland
Eye, Ear, Nose and Throat:
Frederick C. Cordes, San Francisco
Lawrence K. Gundrum, Los Angeles
A. R. Robbins, Los Angeles
Lewis Morrison, San Francisco
General Medicine:
Mayo H. Soley, San Francisco
O. C. Railsbach, Woodland
Lambert B. Coblentz, San Francisco
John Martin Askey, Los Angeles
General Surgery:
Frederick L. Reichert, San Francisco
C. J. Baumgartner, Beverly Hills
Orthopedic Surgery:
Frederic C. Bost, San Francisco
Hugh Jones, Los Angeles
Thoracic Surgery:
John C. Jones, Los Angeles
H. Brodie Stephens, San Francisco
Industrial Medicine and Surgery:
Rutherford T. Johnstone, Los Angeles
John E. Kirkpatrick, San Francisco

Plastic Surgery:
George W. Pierce, San Francisco
William S. Kiskadden, Los Angeles
Neuropsychiatry:
Karl M. Bowman, San Francisco
John B. Doyle, Los Angeles
Obstetrics and Gynecology:
Daniel G. Morton, San Francisco
Donald G. Tollefson, Los Angeles
Pediatrics:
E. Earl Moody, Los Angeles
William C. Deamer, San Francisco
Pathology and Bacteriology:
Alvin G. Foord, Pasadena
Alvin J. Cox, San Francisco
Radiology:
R. R. Newell, San Francisco
John W. Crossan, Los Angeles
Urology:
Clark Johnson, San Francisco
Albert J. Scholl, Los Angeles
Pharmacology:
Windsor C. Cutting, Menlo Park
Clinton H. Thienes, Los Angeles

Speaker Askey: You have heard the nominations for the Standing Committees which are made by the Council. These must be approved by this Body. A motion to approve these nominations is in order.

Dr. Canelo: I move they be approved.

. . . The motion was seconded, put to a vote and unanimously carried.

Speaker Askey: They are approved and the Secretary will formally notify the members of these committees.

At this time I would like to call your attention to another typographical error, something that has been left out of the program. That is the presentation of the budget for the next year, which will be presented by the Chairman of the Auditing Committee, Dr. John W. Cline.

Dr. Cline: Mr. Speaker, I move at this time the House go into Executive Session, all members of the California Medical Association and the Executive Secretary being permitted to remain.

Dr. Carr: I second the motion.

Speaker Askey: You have heard the motion and that is that the House go into Executive Session and that all members of the California Medical Association and the Executive Secretary, and do you wish, Dr. Cline, the Public Relations Counsel and the Legal Counsel?

Dr. Cline: Yes.

Speaker Askey: In explanation of that, before I put the vote to you, it is only right that I call attention again to what an Executive Session means. An Executive Session means that there will be free and open discussion of all the problems presented at that time. The purpose is that there may not be erroneous ideas as to what occurred promulgated unwisely. It is a provision of parliamentary law by which an adequate discussion may take place without any brakes being put on. The brakes which are put on, however, are these: That by entering into an executive session you pledge your honor as a gentleman that such actions and such remarks and statements which are made are private and are not to be promulgated without action of the House. Action of the House made in Executive Session is final. It will stand after coming out of the session so that the action will be an open hearing. However, if you vote for Executive Session those remaining are honor bound that no discussion outside of the facts and discussions be made. This is brought to your attention forcibly because at one Executive Session of this House it was not fifteen minutes later that one of the delegates, sitting in our session, ran to the telephone and called one of the worst enemies of the medical profession and told him everything that had been said. That is not a gentlemanly action and it was, I am sure, by error that it was done, I hope. But, in order that there may be no excuse that you didn't understand, I am telling you very emphatically.

There is a motion before you now that we go into Executive Session, and that all members of the California Medical Association and the Executive Secretary, the Legal Counsel and the Public Relations Counsel be allowed to stay.

. . . The motion was put to a vote and it was unanimously carried. . . .

Speaker Askey: The Sergeant-at-Arms will please clear the room.

Dr. Hoffman (Sergeant-at-Arms): May I have the assistance of Credentials Committee?

Speaker Askey: You may have the Credentials Committee assist you.

Dr. DeLos Reyes: Will you assist the Sergeant-at-Arms. A recess will be declared until the Sergeant-at-Arms reports the room is cleared.

. . . Short recess. . . .

. . . The House of Delegates went into executive session, from which it rose at 6:05 P.M.

Speaker Askey: We are now out of Executive Session and in recess. Your Speaker will call attention to the fact that the rest of your business will now start this evening with the reports of your committees. There is a great deal of work and discussion and we hope that you will be back at the meeting right on time.

Remember, there is another meeting of the C.P.S. Administrative Members and unless we are very good and conserve our time we may run late.

Dr. Kneeshaw: Can we dispose of this matter now?

Speaker Askey: Dr. Kneeshaw, no, for this reason. There is a resolution which has been introduced to the committee which deals with the dues. It was thought best, in order that the whole matter be taken care of, that we bring it up then, because the committee is introducing it. Therefore, it is in order at the time of the report on resolutions that the matter be discussed.

Is there a motion to recess until 8:00 o'clock? If so, it will be entertained.

Dr. Hoffman: I so move.

Dr. Kneeshaw: I will second the motion.

. . . The motion was put to a vote and it was unanimously carried. . . .

Speaker Askey: We will recess until 8:00 o'clock in this room.

. . . The meeting recessed at 6:15 P.M. . . .

Post-Recess Meeting

. . . The House of Delegates re-convened at 8:00 P.M., Thursday, May 9, 1946.

Speaker Askey: The House will be in order please.

Is the Chairman of the Credentials Committee here? Would you report, Dr. DeLos Reyes?

Dr. DeLos Reyes: Mr. Speaker, there is a quorum.

Speaker Askey: The House will rise out of recess and it will now be in regular session.

The next order of business is the reports of the various Reference Committees. The first is the Report of Reference Committee Number 1 of which Dr. D. G. Delprat is Chairman. Dr. Delprat!

Report of Reference Committee No. 1

Dr. D. G. Delprat, *Chairman*

Dr. G. Dan Delprat (Chairman): Mr. Speaker: According to the By-Laws, Section 6, Chapter III, the Chairman of the Reference Committee is required to read his entire report before taking up each individual article for discussion. The Chairman of this Committee respectfully submits the motion that the By-Laws be dispensed for the time being on this particular topic so that each article can be taken up individually to save time.

Dr. Cline: I will second the motion.

Speaker Askey: I take it that the proper motion is to suspend the rule for this one order of business. It does not rescind the By-Law. It is merely rescinded as a rule for this one order of business and is before you as stated. This requires a two-thirds vote to suspend.

Dr. Remmen: To save time, I amend the motion by asking that it also be applied to the Report of Reference Committee Number 2.

Speaker Askey: I think it should be applied to all committees or none, depending upon your wishes. If you wish to make that a motion to include all committees, to save time, I think it would be in order.

Dr. Remmen: I so move.

. . . The amendment was seconded, put to a vote and carried unanimously. . . .

Speaker Askey: There is now before you the adoption of the motion that this rule be applied to the reports of all committees. This is the motion as amended.

. . . The motion was put to a vote and it was unanimously carried. . . .

Speaker Askey: It is carried by a majority vote, a two-thirds vote, and the rule is suspended for this session only and in this one particular, which is that the Chairman of each committee may report part by part as decided here.

Dr. Delprat: Reference Committee Number 1 has studied the *Report of the President* and recommends that it be accepted.

Dr. Cline: I second the motion.

. . . The question was called for, the motion was put to a vote and it was unanimously carried. . . .

Speaker Askey: It is carried.

Dr. Delprat: The committee has also carefully studied the *Report of the President-Elect* and moves it be accepted.

Dr. Shipman: I second the motion.

. . . The motion was put to a vote and it was unanimously carried. . . .

Speaker Askey: It is carried. The report is accepted.

Dr. Delprat: The committee has also carefully studied the *Report of the Speaker of the House* and moves its acceptance.

Speaker Askey: Dr. Kress calls my attention to the fact that I may ask if there is any objection to the acceptance of the recommendation of the Chairman of the Committee and, hearing none, the Chair will announce it is carried. We will give you opportunity to speak. Hearing no objection, this part is adopted.

Dr. Delprat: The committee recommends the adoption of the *Report of the Vice-Speaker.*

Speaker Askey: Is there any objection—hearing none, it is adopted.

Dr. Delprat: The committee recommends the adoption of the *Report of the Chairman of the Council.*

Speaker Askey: Is there any objection—hearing none, it is adopted.

If there are several reports you may read the list of the reports of the various officers and then move they all be accepted as printed.

Dr. Delprat: The committee recommends the adoption of the *Report of the President of the "Trustees of the California Medical Association"*; the committee recommends the adoption of the *Report of the Legal Department;* the committee recommends the adoption of the *Reports of the District Councilors of the First, Second, Third, Fourth, Fifth, Sixth, Seventh and Eighth District.*

Speaker Askey: Hearing no objection, the Reports are adopted.

Dr. Delprat: In regard to the *Report of the Councilor of the Ninth District,* it was brought to the attention of the committee that certain statements in that report are not exactly accurate. The committee, therefore, recommends deletion of part of page 22 of the *Pre-Convention Bulletin* in the next to the last paragraph, the second sentence commencing "California Physicians' Service," down to eliminating the "Garfield Group." This statement we have been told is not exactly accurate and Reference Committee Number 1 recommends the amendment of that report with the deletion of those two sentences.

I so move.

Dr. Madeley: I will second the motion.

Speaker Askey: Is there discussion on the deletion of this part of the report?

. . . There being no discussion, the report was accepted as amended. . . .

Dr. Delprat: The committee recommends the adoption of the *Reports of the Councilors-at-Large* and the Reports of the following Standing Committees:

(a) *Executive Committee;* (b) *Auditing Committee;* (c) *Public Policy and Legislation;* (d) *Associated Societies and Technical Groups;* (e) *Health and Public Instruction;* (f) *History and Obituaries;* (g) *Hospitals, Dispensaries and Clinics;* (h) *Industrial Practice;* (i) *Medical Economics;* (j) *Medical Education and Medical Institutions;* (k) *Medical Defense;* (l) *Publications;* (m) *Postgraduate Activities;* (n) *Public Relations;* (o) *Scientific Work;* (p) *Report of Editorial Board;* (q) *Committee on Participation of the Medical Profession in the War Effort;* (r) *Committee on Local Arrangements;* (s) *Committee on Physicians' Benevolence;* and the (t) *Committee on Organization and Membership.*

Speaker Askey: Is there any objection to the adoption of these reports? Hearing none, I declare them approved.

At this time I think it would be in order and fitting that we stand for a couple moments in honor of the number who have died during the past year. I think we should stand a moment in appreciation.

. . . The members stood and observed a moments' silence in honor of the departed members. . . .

Speaker Askey: Proceed, Mr. Chairman.

Dr. Delprat: The Reference Committee was particularly impressed with the *Report of the Cancer Commission.* The report that was submitted to the Council will be printed later in the Proceedings of this House. We respectfully recommend the adoption of this Report.

Speaker Askey: There is a recommendation to adopt this report. Hearing no objection, it is adopted.

Dr. Delprat: The committee recommends the adoption of the *Report of the Advisory Committee to the Bureau of Vocational Rehabilitation;* the *Committee on Emergency Maternity and Infant Care;* the *Report of the Liaison Representative to California Veterans' Committee;* the *Report of Postwar Planning Committee;* the *Report of the Committee on Adoption Laws;* the *Report of the Local Committee on Arrangements for the Convention of the American Medical Association,* and the *Report of the Advisory Planning Committee* as well as the *Annual Reports of the County Medical Societies.*

I move the adoption of this section of the report.

Speaker Askey: You have heard the motion; if there is no objection, that will be considered as your wish. I hear no objection, the Reports are declared adopted as recommended.

Dr. Delprat: We come now to the *Committee on Prepaid Medical and Hospital Care,* under the chairmanship of Dr. Chandler. This report received a great deal of attention from this committee and our committee unanimously recommends the adoption of the Report down to Number 5, in the second column on page 31. I so move.

Dr. Cline: I will second the motion.

Speaker Askey: If you vote for this motion you will be accepting this part of the Report of the Chandler Committee up to and including point 4. Is there discussion on this? That is, recommendation number 4. If not, the motion for the adoption of this part of the Report is before you. . . . There being no discussion, the motion was put to a vote and it was carried. . . .

Speaker Askey: It is adopted. The motion is carried. Will you continue, Mr. Chairman?

Dr. Delprat: Section 5 of this particular committee's report induced considerable discussion and received most of the attention of the Reference Committee. Many of the Delegates appeared before the committee to debate this particular point. Some of the delegates did not understand. Some of them did not like the osteopathic physicians in there and some of them demanded that the California Physicians' Service be not identified with them in any way, shape or form. They did not want to be mixed up with this group of persons who are licensed as physicians and surgeons under the laws of the State of California to perform the service licensed by the State Board of Medical Examiners.

Other delegates pointed out that the principal purpose of the California Physicians' Service was to promote on a voluntary basis the principle of prepaid medical care and that California Physicians' Service should welcome the assistance of all groups that would further that service.

The Chandler Committee helped the Reference Committee a great deal with that viewpoint. The Reference Committee has reworded this section as I shall read to you in a minute. The general result of the rewording of the Reference Committee is to the effect that the word "osteopathic" be omitted and, further, that the osteopath be placed in a subsidiary position as indicated by the following. The Reference Committee is aware that payments in the past have been made to certain ancillary medical services on an indemnification basis, such payments being made to the patient to indemnify him in the case of the necessity of laboratory fees, nurses, anesthetists, assistants in the hospital, out-patients and et cetera. The California Physicians' Service have in fact made payments to osteopaths.

The committee in its report substituted for Section 5, in place of the words "osteopathic physician and surgeon," the following which I will read in just a minute. This principle, however, of indemnification does not apply to the Veterans' program under the contract with the Veterans' Bureau. This whole discussion does not apply to the Veterans' program. Under the Veterans' program payments can only be made to professional members of California Physicians' Service. Indemnification of the Veteran patient for other services is strictly excluded. An osteopath, however, could receive a payment if he were called in consultation in which a professional member of the California Physicians' Service had been called and he would then become a sub-contractor and he will be given the money to pay the osteopath. This explains the words which I will read in a minute at the close of the substituted or the amended paragraph.

Paragraph 5 as amended by the Reference Committee reads as follows:

> That the beneficiary member be free to choose any physician and surgeon holding an unrevoked and valid license issued by the State Board of Medical Examiners, and that the California Physicians' Service make payments to such physician and surgeon chosen by the said beneficiary whether or not such physician is a physician member of the California Physicians' Service, and, further that the California Physicians' Service make provision to indemnify the patient for services at a rate not to exceed the same fee schedule rate, rendered by other licensed physicians and surgeons in accordance with the contractual commitments of the California Physicians' Service.

Mr. Speaker, I move the adoption of this section of the Report.

Dr. Cline: I will second the motion.

Speaker Askey: The intent of this, and for the clarification of the House, is that your committee recommends that the report be amended by the substitution which the committee made in place of the number 5 portion, which would be deleted.

It is now open for discussion. The motion is to accept the substituted paragraph.

Mr. Chairman, will you read your substitute amendment again?

. . . The substitute amendment was re-read by the Chairman, Dr. Delprat. . . .

Speaker Askey: Dr. Canelo!

Dr. C. Kelly Canelo (Santa Clara County): I rise to raise a question on that amendment proposal. I am not raising the question of the osteopathic physicians and surgeons as members of the medical profession. As I understand this condition, this paragraph is putting a penalty on the man who is a physician member of the California Physicians' Service, since it states that the man who is not a member can be engaged by the beneficiary member and will be paid according to the California Physicians' Service fee schedule on an indemnification basis at the then level, free to bargain with the beneficiary member for additional service, even though as a member of the group he may be fully covered by California Physicians' Service. I would like to have a legal interpretation of my point.

Speaker Askey: Dr. Canelo asks for the legal interpretation on this point. We will ask one of our attorneys, Mr. Hassard, or Mr. Peart, to answer this question if they can.

Mr. Hassard: Mr. Speaker and Members of the House of Delegates: As I understand the substitute paragraph 5, it would involve three things; first, that the membership in California Physicians' Service continue to be limited to Doctors of Medicine; second, that California Physicians' Service may make payments for professional services rendered, either to physician members, or to physicians who are not members of C.P.S. but who are Doctors of Medicine, and, third, that it may likewise make payments only, however, on a reimbursement basis to physicians and surgeons who may or may not be Doctors of Medicine.

The third, the last clause, in the substituted paragraph would cover any physician and surgeon but as to the equality of payment, the recommendation provides that indemnification may not exceed the rate or rather the fee schedule that is provided for physician members. It does not provide that the indemnification must equal the amount paid to the physician member.

Now, actually, in the application of the combined service and indemnity plan which C.P.S. will be engaged in, as you have already approved the first four recommendations and recommendations number 1 and 2 provide that C.P.S. shall engage in both a service plan for the low income group and an indemnification plan side by side, actually in the operation of the combination service and indemnity plan, the indemnities will have to be at a fixed dollar rate per service. It is impossible to have a reimbursement or indemnification to the patient to be applied against a physician's statement unless that indemnification or reimbursement be figured in terms of so many dollars, or some procedure so that the indemnity is bound to be a particular amount, a particular service, month in and month out. However, under the service plan, the physician members will continue to receive their pro-rata of the amount available month by month. Therefore, it seems inherent in the proposed plan, as the Chairman of your committee proposed and as the Reference Committee is submitting to you, that if C.P.S. financially does not do too well the physician members will receive less than par, but if it does well financially the physician member will receive more than par. So that actually those physicians who are physician members of California Physicians' Service in substance gamble a bit. They will not be able to charge their patients more than the amount they receive from C.P.S. for those who qualify in the income group, but the amount they receive for those services will depend upon the success of C.P.S.

On the other hand, those physicians who choose not to be physician members of C.P.S. will receive an indemnity that will not vary but it will be a matter of the contract not between the doctors and C.P.S. but between the beneficiary members and C.P.S.

I might state that on a service plan and a contractual arrangement as between the physician and the plan, the physician agrees to accept whatever plan has the full compensation. In an indemnity or reimbursement plan, the plan is between the patient and the plan. A physician does not contract to accept anything in effect for his services but the plan contracts with the patient to pay a certain definite amount for a particular service.

The ultimate answer to Dr. Canelo's question is that physician members of C.P.S. could be penalized if the California Physicians' Service is not able to make enough money to pay indemnities for those services rendered to beneficiary members who go to physicians who are not physician members or, on the other hand, they could get more than the physician who chose to stay out of C.P.S. if the plan succeeded financially.

Dr. Goin: Would the members please give me the floor?

Speaker Askey: Dr. Goin, President of California Physicians' Service, wishes to speak. This would require unanimous consent in order to have Dr. Goin address us. I hear no objection—you are granted the privilege.

Dr. Goin: Mr. Speaker and Members of the House, thank you.

I think that we will all agree that we can't at once face an issue and evade it. I think we should ask ourselves at this point, are we or are we not opposed to any method of compulsory health insurance. If we are, and I think we are unanimous, then we should ask ourselves next—do we believe that voluntary health insurance is an adequate defense against compulsory health insurance? If we do, and I think we do, we should ask ourselves next whether we believe truly and in our hearts in voluntary enterprise and free medicine. Now if we do, we come to the question as to whether or not a free American citizen has a voice to choose the kind of health care that he wants.

I am sure I don't have to remind anybody that I am a Doctor of Medicine. I am sure that most of you know that I am a radiologist and that I derive my living from patients referred to me from other doctors. I have never had a patient from an osteopath or a chiropractor or any other irregular practitioner. I no more believe in them than you do but I can't find it in my heart to dispute the right of an American citizen to choose an osteopath for his doctor if he wishes.

The State of California has seen fit to license these people to practice medicine and surgery. There are a great many people in California, enough to have cast the decisive ballot on the initiative, who believe they give good medical care. You don't and I don't, but nevertheless a great many people do.

If the osteopathic physician and surgeon is excluded from a voluntary health insurance plan it can be reasonably argued that we are not offering the people what we say we are—a free choice of physician. Now, I don't know whether we want to offer them free choice of physician or not. Perhaps we only want to offer them free choice of Doctors of Medicine and, if we do, I have no particular quarrel with it, but, if we don't, and we really mean to give them free choice of physician and surgeon, then I think we must offer the free choice of any person who has a valid and unrevoked license to practice medicine and surgery in California. I think it is a tremendous mistake to evade the issue by trying to carry water on both shoulders and saying that that group shall do thus and so and this group shall do thus and so and, if we do that, we are only going to encourage those members who are now heartily in our support to cease being physician members of California Physicians' Service because you are placing a penalty upon being a physician member by relieving non-member physicians of their moral and even contractual obligation to supply medical care to a certain income group on a service contract. You are opening the door for him to bargain with his patient, saying, "Well, since you will get $80.00 back from California Physicians' Service, you can really afford to pay me $200.00 more," whereupon the entire point and purpose of California Physicians' Service is invalidated and, whereas, the radical left wingers and the Murray Committee and all such people will say, "See, that is what we told you; they can't do it and we must do it for you."

Now, gentlemen, think seriously before you adopt this particular provision of the report.

Speaker Askey: Dr. Madeley!

Dr. Madeley: May I ask legal counsel this question? If such a substitute resolution is adopted, what is the legal aspect and what would we be required to pay in regard to a fluctuating unit value? How will this indemnification process work if our unit value is $2.00; $1.75 or $2.25? What are we really liable to pay; full par value or the going unit value?

Speaker Askey: Mr. Hassard, will you answer that question?

Mr. Hassard: Mr. Speaker and Members of the House of Delegates: The language of the recommendation is not specific on the question asked by Dr. Madeley. However, the Board of Trustees in operating a pre-payment plan cannot carry out the recommendations and the other recommendations that tie in with it. Please do not overlook the fact that the first two recommendations that have already been adopted provide for a combination service and indemnity plan. The Trustees cannot carry that into effect unless they establish a fixed fee schedule for indemnification or a reimbursement method as a matter of contract between C.P.S. and the beneficiary members. The beneficiary members have to know how much in dollars they are going to get in the event of a particular illness or injury. Therefore, while it is not contained in the recommendation in so many words, as a matter of practice, the indemnification or reimbursement would have to be a fixed amount and remain fixed while the service schedules would have to vary up or down with the financial success or lack of success of California Physicians' Service. Do I understand the question?

Dr. Madeley: Thank you.

Speaker Askey: Is there further discussion? Dr. Chandler!

Dr. Chandler: Mr. Speaker and Members of the House: I would like to appear on behalf of the substitute recommendation here, number 5. As a member of this committee that studied it, I think the substitute, perhaps, is better worded than the one we submitted to you in the beginning.

The thinking of the committee behind this recommendation was along these lines: In the first place, we believe that we as doctors and as in an Association could furnish a very liberal, if not an entirely free, choice of physician on the part of the beneficiary. I am speaking now in response to Dr. Canelo's question as to whether or not it is proper for C.P.S. to pay a physician who is not a physician member of C.P.S. We believe they should be paid. If a beneficiary chooses to select a doctor who is not a member, that right should not be denied.

Keep in mind, also, those of you who are raising that same question in your mind, that this present contract with the Veterans' Administration is with physician members of C.P.S. only. The present Veteran-C.P.S. contract does not include any method of payment to a physician who is not a member of C.P.S., a physician member of C.P.S. I think I am correct in that.

I do not think Santa Clara County has any more chiselers in the medical profession than any other county and if our committee believes that those physician chiselers on fees and rates paid for professional service will be 10 per cent of the medical population or less all over the country, I do not think we are too far off. I think Mr. Bowman explained that to the Administrative Members on Tuesday. At the present time the complaints concerning overcharges are less than 4 per cent, involving less than 4 per cent of the doctors. It is probably going to be the same 4 per cent all of the time.

This question of the indemnity rate and the legal aspect of the contract between C.P.S. and the subscriber has been explained to you, I think adequately, by Mr. Hassard. As you know, in order to execute this recommendation or a series of recommendations, it means that indemnification must be provided and technicalities and legalities arranged for.

Concerning the question of the osteopath, I haven't any more belief in that group of licensed physicians than anybody else. Yet they do hold a legal right to practice medicine and surgery in every respect even as you and I. I don't know what percentage of the subscribers we would lose to the osteopathic physicians and surgeons, those licensed by the Osteopathic Board, in preference to those licensed by the Medical Board. I venture the opinion that it would be a small percentage. If they are excluded from the subscribers or the beneficiaries excluded from indemnification in case they chose such a licensed physician and surgeon, I am quite sure we would have a fairly active opposition.

I think most of you at the meeting have already seen the folder passed around by the Osteopathic Association of California, "Stop, Look and Listen before you join any prepaid medical care plan," and so forth and so on. Anticipate the program of public relations, publicity and the selling campaigns that will go on in your county and mine if this thing is adopted. The program that would be initiated by that same group before C.P.S.'s representatives and field workers and the doctors got a chance to do any work would do us a lot of harm. I think it would be substantial opposition to the successful growth of C.P.S.

Those are some of the points that were in the minds of the committee when we made this recommendation, and as I have read over this substitute number 5 recommendation, I think the wording is even better than the one our committee proposed. I think you ought to accept this recommendation and in doing so you are making it legal and opening an avenue of operation for the Administrators of C.P.S. to do what they are really doing now. I would urge you to adopt the substitute recommendation.

Speaker Askey: Dr. Anderson!

Dr. Max Anderson: Mr. Speaker and House of Delegates: I have before me here "The Crises of the Free Market," a little booklet published by Professor F. A. Harper. He is a professor of Marketing at Cornell University. I think there is one little paragraph in that that has the crux of the whole matter. It reads:

> "Our most important reconversion problem is the recovery of our economic and personal freedom. The heart of that problem is prices. A free economy, free enterprise and free men cannot exist without free prices. All prices—all types of prices."

Here is a little thing published by the Committee for Constitutional Government which states "The difference between free prices and prices dictated by government is not hard to state." Which gives the maximum of prosperity? That is the thing we are interested in. The answer is free prices. Why? Here is the reason. The producers will try to sell dear; consumers always try to buy cheap. This fundamental law of man's nature has not changed in a thousand years.

The indemnification type contract is the only one that fulfills his requirement; namely, that of free prices. The service type of contract is objectionable because it does not give free prices and injects a third party which holds the power of the purse and therein interferes with the kind of treatment, the amount of treatment and who gives the treatment.

I urge that this amendment be left as reported by the committee.

Speaker Askey: Is there further discussion? Dr. Crane?

Dr. Crane: Having served on the Chandler Committee, I entered into the discussion as to whether or not osteopaths should be included in this plan. You will recall that we had the slogan, "The Patient Shall Have the Free Choice of Physician at All Times." Probably we defeated compulsory health insurance in Sacramento by the use of that slogan. At the hearing of the Murray Committee in Washington that slogan was used over and over again.

I had the opportunity to help prepare a statement to be given to the President of the United States by the delegates of one of the states. They had an appointment to meet him and they wanted to give him a prepared statement. They worked several nights until three or four o'clock in the morning, I might say, and when the delegates of that state saw the President we all huddled around, and wondered, "Well, what did Mr. Big"—they nicknamed him that—"say?" You know where they were from. He said. "You men from the medical profession claim that the beneficiary has the free choice of the physician?"

"Yes, that is right."

"In your state, however, you are not practicing what you preach; these physician members who are not members of your service plan have no right to give benefits to the beneficiaries; isn't that right?"

"Yes, that is true."

"Well, therefore, you are not practicing what you preach."

In California we must let the patient have free choice of the physician and the period will be right there. The osteopaths regularly hold licenses to practice medicine and surgery and I really believe that we will be criticized very severely and taken to task if we don't do that.

Speaker Askey: Dr. Shephard!

Dr. John Hunt Shephard (Santa Clara County): I am appearing for two reasons. One is a little historical situation and the other is to ask an opinion from legal counsel.

You know, this fight that we have had for years in regard to the standing of chiropractors and osteopaths reminds me very much of the fight many, many years ago which went on between the so-called eclectics and homeopathic physicians. I don't know if there is anyone in the room tonight who was in practice or was at medical school at the time Dr. Simons, who at that time was Editor of the *American Medical Journal*, waged a very strong fight in the A.M.A. to bring within the fold of the American Medical Association, the homeopaths. He was ridiculed, condemned and almost ostracized. My source of information on that fight came from Dr. Johnson who was Dean of Medicine at Northwestern.

As I look into the future I can see the time when we are going to bring within our fold the osteopaths and make doctors out of them. So I have no particular fight, whether it is osteopaths or non-osteopaths, that render service to the members of the California Physicians' Service. This is just a little prophecy I am making. We will see how it comes out.

There is another factor I wish to bring forth and that is this. Under Section 3 of this recommendation from our committee, which we have already adopted, there stems the fundamental theory upon which we started California Physicians' Service. You all know that at the time we started California Physicians' Service we started it on borrowed money from C.M.A. to the sum of $40,000.00, and $5.00 from each one of the members. That was our capital. In other words, we were not financially able to assume the personal responsibility and the legal responsibility of establishing an insurance company, which every indemnity plan is. Our plan comes directly under the Insurance Law of this State in regard to insurance companies.

In adopting Section 3 we have assumed a liability we may not be able to meet. In other words, if we meet the fee-for-service plan and there is nothing left for us, we get nothing. That is perfectly all right. If we adopt the indemnity plan we have a capital factor which reverses back of us in order to make good our contracts.

The question I wish to bring up from the legal standpoint is this. It seems to me, by including Section 5 or the modification of Section 5, as has been proposed, there is going to be a reaction in our hospitals. If we allow osteopaths to take care of the members of California Physicians' Service and they run to them to fix a broken leg or cut out a ruptured appendix or what-not, where are they going to hospitalize their patients? In Santa Clara County no man is eligible to work in either one of our two hospitals unless he is a member of the Santa Clara County Medical Society. I think the same thing holds true of many counties of the State.

Suppose we allow our physician members to assume full responsibility for the care of these members and a patient comes up that has to be hospitalized. Where is he going to hospitalize that patient? We will have to change our By-Laws in both the hospitals in Santa Clara County if they can do so. I do not believe that either of the hospitals will do so. I can see where there is going to be a tremendous uproar brought by an occasional person, and I can visualize that there will be some individual problems directly or indirectly connected with the legal fraternity who will intentionally employ an osteopath so that he can be turned down by a hospital in order to bring a fancy suit against the hospital and C.P.S.

I would like the attorney's opinion in regard to that matter.

Mr. Hassard: Mr. Speaker and Members of the House of Delegates: If I understand correctly the proposal contemplated originally in the Chandler Committee report and in the substitute recommendation number 5, all that C.P.S. would be doing, if they include the services of an osteopath, would be to reimburse the patient at some fee schedule for all or a part of the cost of the services of the osteopathic physician and surgeon. That would not involve any legal or moral obligation on the part of C.P.S. to provide any service, whether medical, surgical, hospital or otherwise. Its only obligation would be to reimburse a certain number of doctors after a service was rendered. Therefore, the hospitals would not be affected at all. They could continue to follow whatever their practice might be. C.P.S. would be in no different position than any other third party that agreed to guarantee some part of the payment of a bill. Do I answer you, Dr. Shephard?

Dr. Shephard: Yes, I believe so.

Dr. Sidney J. Shipman: As a member of the Chandler Committee, I would simply like to say that we knew this provision would arouse a good deal of comment and we were quite aware of the objections which have been raised here. We feel, however, that inasmuch as this has been put into effect in Michigan and it worked very well, it would work well here and that the advantages outweigh the disadvantages.

I would like to propose an entirely different section 5, which I may say has the approval of your legal counsel, to read:

> That the Board of Trustees of C.P.S. be authorized to reimburse at such rates as they may determine for service rendered to beneficiary members by physicians and surgeons who are not C.P.S. physician members.

It seems to us somewhat clearer and more succinct than those which have gone before.

Speaker Askey: Do you move that as an amendment to the amendment?

Dr. Shipman: I move that as an amendment to the amendment.

Dr. Madeley: I will second the amendment.

Speaker Askey: This amendment is before you now. We must discuss the amendment now.

Dr. Madeley: May I cite a specific case? Occasionally there will be someone in the Los Angeles area, and this hasn't happened in our northern area yet, whose child, for instance, developed an acute appendix. The parents seek out a physician and surgeon. They have read that he is a "Physician and Surgeon" on his window; they go into his office; this child's appendix is taken out and then we get the bill or C.P.S. gets the bill. The surgery has been done by an osteopath.

In the beginning we refused to pay those claims. However we ran into some very disagreeable situations whereby an employer who was possibly paying part of his employee's C.P.S. prepaid medical care and then he comes back to C.P.S. and says "My employee who was guaranteed full coverage now has had his child's appendix out and you refused to pay the bill. If that is going to happen we will cancel our whole contract." We stand to lose 200 or 300 beneficiary members by failing to pay one bill. Those claims the Board of Trustees through the Administrative Members have paid and satisfied.

This problem, I think, the osteopaths recognize has been a problem before the C.M.A. for many years, at least the last four or five to my knowledge. I think it is wrong to throw into the lap of California Physicians' Service the problem of trying to solve this discrepancy of how much we are going to recognize the osteopaths in this State. I heartily approve of Dr. Shipman's suggestion and I think we should leave it up to your Board of Trustees and Administrative Members to take care of this problem, at least temporarily.

Speaker Askey: Dr. Canelo!

Dr. C. Kelly Canelo (Santa Clara County): I rise to discuss the proposed paragraph 5 and its amendment because under both the original proposal and the amendment we guarantee or offer free choice of physician not only the M.D. but the osteopath. As I originally stood up, I was not talking about the osteopathic provision of paragraph 5 but was merely referring to the M.D. provision of it. Under the provision of paragraph 5 as originally presented and as amended, the C.P.S. professional members or physician members, if they choose to call them that, guarantee to render service to those people with a limited income, whatever that established limitation is, and to accept as full payment the unit value paid to him by the California Physicians' Service. The non-professional member or non-physician member under this provision will be allowed to take care of these beneficiary members and will be reimbursed under some sort of an indemnity provision and he does not guarantee to the beneficiary member that he will be satisfied with the fee as returned to him by California Physicians' Service.

We will, therefore, have conditions where we have two classifications of M.D.'s, the M.D. who will take full coverage and the M.D. who will not, and both classifications will have the approval of California Physicians' Service. There will be a definite tendency for California Physicians' Service professional members to drop out and become non-professional members since they can still care for those beneficiary members but might have the benefit of an added fee arranged with the beneficiary member. We will there be faced with a definite tendency toward a diminishing roll of professional membership and I believe that there is a very definite unfavorable reaction on the part of the public and it will very definitely unfavorably affect our stand and our argument against compulsory medicine.

I would like to ask the Reference Committee if it would consider presenting paragraph 5 as two separate items; one part of paragraph 5 to deal with the M.D. and one part to deal with those who are not M.D.'s.

Speaker Askey: Does the Chairman of the Committee wish to answer that question of Dr. Canelo's?

Dr. Delprat: Mr. Chairman, we admit that this paragraph 5, as we rewrote it, has three distinct items in it. I would be very pleased to split that up in any manner, shape or form that suits the House of Delegates. I understood that you accepted an amendment to the amendment of number 5 which is written out here the way it was given to me. Would you like me to read it? Dr. Shipman read only the part that was affected by the second half of the thing that we wrote for number 5. Shall I read it all as a unit?

Speaker Askey: I think you had better leave it alone. You are at the end of the amendments. You cannot go further than the third degree and your only way out, at the present time, if you wish to start over, is to either withdraw your amendments or vote them down and then start over. This amendment which stands before you is on the second degree; it is an amendment to an amendment and you must either withdraw it or turn it down if you do not wish it to stand as proposed.

Dr. Madeley: May we have the amendment to the amendment read?

Speaker Askey: Dr. Shipman, will you read your amendment again?

Dr. Delprat: May I do that for you, sir? It is in front of me. The reason I brought that up was that I knew this was the second amendment to an amendment; it could not go any further without this clarification. The amendment of Dr. Shipman will read as follows:

> That the beneficiary members be free to choose any physician and surgeon holding an unrevoked and valid license issued by the State Board of Medical Examiners and that the California Physicians' Service make payment to such physician and surgeon chosen by the said beneficiary whether or not such beneficiary is a member of the California Physicians' Service, and, further, that the California Physicians' Service be authorized to reimburse at such rates as may be determined for services rendered to the beneficiary member by the physician and surgeon who is not a C.P.S. beneficiary member.

Speaker Askey: Dr. Shipman, will you clarify further your amendment?

Dr. Shipman: My intent was to substitute the following for number 5 in toto, namely:

> That the Board of Trustees of C.P.S. be authorized to reimburse at such rates as may be determined services rendered to beneficiary members by physicians and surgeons who are not C.P.S. physician members.

Now, actually, what Dr. Canelo says is quite true. All of us who are members of C.P.S. will suffer to the extent of $5.00 which we put into the kitty when we began and because of the agreement which we made with C.P.S. when we subscribed, namely, that we will not charge extra fees over and above for the lower income group.

We talked this over with Mr. Ketchum, the Secretary of the Michigan State Medical Plan, who has had the same thing in effect. Their experience is that the objection which Dr. Canelo raised, and which is true, actually has very little bearing because the few people who are inclined to chisel do not last long in a plan such as this. Patients themselves soon seek out the people or the doctors who play fair with them; therefore, we feel that although a danger exists, it doesn't have very much actual bearing upon us.

Speaker Askey: This clarification means then that this would be the substitution for 5, if adopted, instead of the one that was given by Dr. Delprat.

Dr. Remmen: I move the previous question on the amendment to the amendment.

Dr. Kneeshaw: I will second the motion.

Speaker Askey: There is a motion to move the previous question. This requires a two-thirds vote for the adoption of this rule and there is no discussion allowed.

All of those in favor of the motion which is to call for the previous question, which means to close debate on this amendment, say "aye," opposed "no."

. . . A vote was taken on the motion. . . .

Speaker Askey: The Chair is in doubt. All of those in favor of this motion will please rise? The motion is to close debate and vote the amendment without further debate. This is the amendment by Dr. Shipman. In other words, if you vote in this, you will merely call for a vote on Dr. Shipman's amendment without further debate.

. . . A standing vote was taken on the motion. . . .

Speaker Askey: The motion is carried by a two-thirds vote. We will, therefore call for a vote on Dr. Shipman's amendment. This does not require a two-thirds vote—it merely requires a majority.

All of those in favor of Dr. Shipman's amendment will please rise.

A Member: I want to be quite clear before this vote is taken. I want to be sure that we understood that even if this amendment is put into the original paragraph 5, we then do not cut off debate on paragraph 5. Is that correct.

Speaker Askey: No, you do not. You still have the privilege of debate on the whole question, sir.

Dr. Delprat: A point of order.

Speaker Askey: State your point.

Dr. Delprat: My point is this: "to reimburse at such rates as may be determined." I assume it means reimburse the beneficiary members. Now, under the Veterans' contract, that is not possible.

Speaker Askey: What is your point of order?

Dr. Delprat: If you vote this in, you are voting the Board of Trustees to do something which it cannot do because the Board of Trustees, if this were voted through and some individual had the care of a veteran and he was an osteopath, the Board of Trustees by its contract would be permitted to reimburse the individual, an osteopath, because of this contract.

Speaker Askey: I will rule on the one point that is before you. Your point of order is ruled out because these are separate contracts and we, as this House, are merely recommending to the California Physicians' Service what should be done; therefore, your point of order is out at this time.

Dr. Cline: I rise to a point of information. May we have information from the legal counsel as to the legality of this provision?

Speaker Askey: This is not discussion. That is a point of information that is desired. Will the legal counsel please answer the question?

Mr. Hassard: Mr. Speaker and Members of the House of Delegates: The amendment that is before the House is as follows:

That the Board of Trustees of C.P.S. be authorized to reimburse at such rates as it may determine services rendered to beneficiary members by physicians and surgeons who are not C.P.S. physician members.

The words "be authorized" is a granting of power; not a command. The amendment would permit the Board of Trustees to adopt a reimbursement schedule at any rate that it saw fit for physicians which would include osteopathic physicians and surgeons because legally the term "physician and surgeon" includes osteopathic physicians and surgeons who would not be physician members but it would not require the Board of Trustees to do it. That being the case, the amendment would have no effect whatever upon existing contracts of C.P.S. because the Board of Trustees is not put in a position of being forced to do anything. It may continue to carry out the contract with the Veterans' Administration which is definitely limited to those physicians who are Doctors of Medicine and, in addition, are physician members of C.P.S.

Speaker Askey: The Chair will now call for the vote.

A Member: We haven't the true situation at all. Dr. Shipman presented a substitute, not an amendment but a substitution.

Speaker Askey: The substitution is an amendment, no matter what you call it.

A Member: Where does it start to amend and where does it leave off?

Speaker Askey: The amendment is to substitute this for the substitution; in other word, what will happen will be this, and I will try to give it to you so you will understand it. If you adopt the amendment which is proposed and which you are to vote on, you then amend the amendment which they proposed and you will have to vote on accepting that. Then, if you accept that, you must accept the main motion and this would be to all intents the final motion. You have to go through two more steps in order to get there. If you accept that, your final motion will be this.

. . . The question was called for. . . .

Speaker Askey: The question is before you. All in favor of Dr. Shipman's amendment say "aye"; opposed "no."

. . . A vote was taken on the motion and it was carried, not unanimous. . . .

Speaker Askey: It is carried and so ordered. The amendment as amended is before you. It is open to discussion.

. . . The question was called for. . . .

Speaker Askey: The question is called for which is on the amendment as amended.

. . . A vote was taken on the motion and it was carried. . . .

Speaker Askey: The amendment is carried. In other words, number 5, as it now stands, is as Dr. Shipman read it. It is adopted and will be printed by the Editor.

Dr. Delprat: That brings us down now, gentlemen, to number 6 as printed in your *Pre-Convention Bulletin*. This particular paragraph was amended by adding the words "from the C.P.S." after the word "receive." It now reads as amended by this Committee:

That all physicians receive from the C.P.S. the same fee according to the fee-for-service schedule.

It is merely an insertion of words there.

I move the adoption of this particular amendment.

. . . The motion was seconded. . . .

Speaker Askey: Is there discussion?

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

Dr. Delprat: We come now to section 7. It states in the *Pre-Convention Bulletin* the words "Directors" and we wish to substitute the word "Trustees." We took the liberty of correcting that word.

I move the adoption of this section as amended to read "Board of Trustees."

. . . The motion was seconded. . . .

Speaker Askey: Is there discussion?

Dr. Madeley!

Dr. Madeley: I should like to move a substitution—that it read this way:

"Board of Directors of California Physicians' Service may revise the fee schedule biennially, this revision to be made upon the recommendation of a committee appointed by the Board of Trustees of the California Physicians' Service and that this schedule be maintained at a level as high as possible to insure the greatest coverage for the greatest number at the maximum practical fee to the physician."

I move the substitution of the "Board of Trustees of the California Physicians' Service rather than the Council of the C.M.A." for the particular reason that we can only pay so much on a fee schedule depending on how much money we have as income. We feel that the Board of Trustees know better how much money we have coming in advance than a committee appointed by the Council and a fee schedule committee appointed by the Board of Trustees can better work than a fee schedule committee appointed by the Council.

Speaker Askey: Dr. Delprat, we could avoid some confusion if you would accept that amendment.

Dr. Delprat: Certainly.

Speaker Askey: There is now before you the acceptance of Dr. Madeley's interpretation of Dr. Delprat's amendment. Is there a second?

. . . The motion was seconded. . . .

Speaker Askey: Is there discussion?

Dr. Donald!

Dr. William G. Donald (Alameda County): These things were thought of by your committee under Dr. Chandler and discussed. All of their objections were brought up by the members of the committee. There are many doctors who do not approve of C.P.S. as it is now constituted. They do not approve of the fee schedule or any part of it. They do not approve of the way it is run. They would feel much happier if an independent body proposed to the Trustees of C.P.S. a fair schedule. I would agree to C.P.S. revising the schedule but so many doctors would feel greater confidence at this time if a neutral body such as the C.M.A. would help in setting the fee schedule so I feel that then C.P.S. would be in a better position. I don't feel myself that C.P.S. is not going to consult with C.M.A. but thereby it would be the doctors of the State and not a corporation that sets the fee.

Speaker Askey: Is there further discussion?

Dr. Cline!

Dr. Cline: I would object personally to the inclusion of the word "may." We have heard recently from a number of different sources that the Internists presented a resolution to that effect and that other members of the profession object to the maintenance of certain fee schedules which they feel might militate against them. They feel that we should have at least biennially some revision of the fee schedule. I think it would be a mistake. I think that hearings should be held and such revisions as are indicated should be made at that time and that provision should be mandatory rather than optional.

Dr. Chandler: For my information do I understand the Chairman of the committee accepted the proposal of Dr. Madeley as the Committee's recommendation?

Dr. Delprat: No. We think the thing should be combined; in other words, we are objecting to the Board of Trustees only when it means "Trustees" and from then on, we didn't object.

Speaker Askey: Is that in answer to your question, Dr. Madeley? It was, perhaps, the fault of your Speaker that there was this misunderstanding. I think in view of the error of the Chair in directing your attention to that change, I should like to start all over and have you give your primary amendment and then we will start all over again.

DR. DELPRAT: My amendment was to correct the section to read "Trustees"; in other words, the word "Directors" was used when the word "Trustees" should have been used.

SPEAKER ASKEY: The only change there is the substitution of the word "Trustees" for "Directors." That is all.

DR. CHANDLER: Before Dr. Madeley has a chance to formally put this up again, I would like to call your attention to the point that he makes in recommending that this again be changed in that his change or amendment would lead to a revision of the fee schedule solely by the Board of Trustees. As it is now, it is compulsory that it be revised biennially. Dr. Madeley's point is that it be at the discretion of the Board. Number 2 of Dr. Madeley's points was that the revision be made by the Board of Trustees or a committee appointed by the Board.

This, again, was discussed by the committee at some length. If you will go back to the original discussion of the committee you will find that changing "Directors" to "Trustees" was an error in grammar and that there was intended to be revised biennially the fee schedule on the recommendation of a committee of outside doctors, not the directing board that is running the business.

I move and urge you to adopt the amendment as recommended by the committee.

. . . The motion was seconded. . . .

SPEAKER ASKEY: Dr. Madeley, do you now wish to make your amendment?

DR. MADELEY: My point of contention is, perhaps, on this basis. We have for the past several years been working on a change of fee schedule. It has taken us a solid year. The Board of Trustees felt exactly as this committee has—that is should be an entire outside group of doctors not connected at all with the California Physicians' Service who would adopt a fee schedule for the entire State. We appointed a Fee Schedule Committee and, first of all, it was very difficult to even get a Fee Schedule Committee together. The committee consisted of five members, extending from San Diego to Eureka. Every specialist that could be brought out was put on this Fee Schedule Committee. They met several times. They had hearings and when it finally came down to voting a radiological fee schedule, even though we had a radiologist on that Fee Schedule Committee, he didn't want to take it upon himself to set fees for the entire profession; therefore, the entire fee schedule was referred to the Pacific Coast Radiological Society who then adopted their fee schedule.

Now, we can pay out in fees as much money as we can collect. We feel, or I, personally feel, speaking as a Delegate and not as a member of the Board of Trustees, if you trust your Trustees, they will spend the money in the best way possible and at least we should have the power to appoint an unbiased fee schedule committee to develop fee schedules that we can adopt and work by. We feel that we are going to be just as unbiased as any other outside group, whether it be the Council of the C.M.A. or anyone else, and we are going to give fair fee schedules that can be workable. We can't put out any more than we can collect and certainly it is only biennially that we can get that many people together for enough time to change your fee schedule. It just hasn't worked out practically in the two years I have sat on the Board so I move that we may revise this fee schedule biennially and "biennially" means, I am sure, that your Board of Trustees will do that as often as necessary, sir. I think you should trust your Board of Trustees enough to have the privilege to appoint the men who are going to adjust that schedule.

SPEAKER ASKEY: Do you move to change the words "Directors" to "Board of Trustees of C.P.S." and add the word "may"?

DR. MADELEY: Yes.

. . . The motion was seconded. . . .

SPEAKER ASKEY: As it stands now, there is a motion to adopt number 7 by amending it to read "Trustees" instead of "Directors"; then there is an amendment to that to change it by adding the word "may" and changing "Council of the C.M.A." to "Board of Trustees."

Now, do we understand it? Is there discussion upon that amendment?

. . . The question was called for. . . .

SPEAKER ASKEY: Dr. Cass!

DR. DONALD CASS: The Council of the C.M.A. has the authority to act on anything pertaining to the Trustees of C.P.S.; isn't that a fact?

SPEAKER ASKEY: That is right.

DR. CASS: Then it would be my opinion that it would be out of order for the Council of the C.M.A. to appoint a committee to tell the Trustees of C.P.S. how much money they are going to pay.

SPEAKER ASKEY: This is a recommendation. The Trustees of C.P.S. could detail to the Council of the C.M.A. to appoint such a committee. I think it would be in order. They wouldn't have to do it but they would probably do it.

Dr. Bender!

DR. WILLIAM L. BENDER (San Francisco): I think there should be a mandatory period of review set. If it is semi-annually and that is too often, then I believe it should be annually. It isn't that we here cannot trust our Trustees. We do, but the Secretary of the Los Angeles County Medical Society pointed out everything we can do to instill confidence of all the physicians, which is shaky in very many localities, in their chance of getting a fair deal under the revision of the fee schedule when they consider them inadequate and unfair. It will instill confidence in any physician member and we all agree that is necessary.

SPEAKER ASKEY: Is there discussion on the amendment?

DR. SHEPHARD: Do I understand that this amendment refers to optional or mandatory?

SPEAKER ASKEY: The Board of Trustees "may."

DR. SHEPHARD: It should be upon this one phase and the insertion of the word "may" is under discussion now in this amendment. I have nothing to say on it. When it came up I was going to make a motion on another factor which is not included in the amendment.

SPEAKER ASKEY: Is there further discussion on the amendment?

Dr. Crane!

DR. CRANE: Personally, I think we are wasting a lot of time on this. I don't think it makes any difference whether the Board of Trustees appoint the committee to revise the fee schedule or whether the C.M.A. Council does it. It is all the same group and I think we might as well let the Board of Trustees do it if they wish and just take a lot of work off the Council of the California Medical Association.

Now, as far as "may," or making it mandatory, I would be willing to say annually rather than biennially but I believe it should be mandatory, at least once a year, to revise the fee schedule.

SPEAKER ASKEY: Is there further discussion of this?

DR. LESLIE B. MAGOON (Santa Clara County): If the word "may" be inserted in the first sentence, it would be my interpretation that that would limit the frequency of the revision to every two years. It is conceivable that since the safety valve of the unit no longer exists that an emergency reduction of that fee might still be necessary if there were an epidemic of some sort.

I think, perhaps, it might be worded to say "at least biennially," leaving it possible to have that revision more often rather than less often, if necessary.

Dr. Delprat: As Chairman of the Fee Schedule Committee for the last year, I would like to see this revision done annually. When our committee of five, as Dr. Madeley mentioned, met very frequently and communicated by mail incessantly, with the help of the Board of Trustees, we cut out a schedule and, judging from the amount of correspondence we have had, I think the volume of business justifies an annual revision.

Speaker Askey: The question is on the amendment. Is there further discussion.

Dr. Shephard: I should like to ask to speak. If we vote upon this question of inserting the word "may" in there, as proposed, and it is carried, does that carry the entire paragraph as now written or it is open for discussion on other points.

Dr. Chandler: I think that is not clear. As I understand it, the amendment inserts the word "may" and revises the appointment of the committee to the authority of the C.P.S. Trustees, not the C.M.A.

Speaker Askey: The choice is up to the Board of Trustees—isn't that what you asked? You asked, Dr. Shephard, if we accept this amendment, if the amendment would still be open for discussion. The amendment will still be open for discussion. The question before you is on the amendment of Dr. Madeley which adds the word "may" and changes the words "Council of the C.M.A." to "Trustees of C.P.S."

Dr. Doughty: A point of information. If this is adopted, it will mean, will it not, that it will be mandatory upon the Board of Trustees to accept the fee schedule as recommended by the committee?

Speaker Askey: No, it does not.

Dr. Doughty: If you insert the word "may," it will not be; if you turn it down, it will be mandatory and there will be no relationship between it and what the committee recommends.

Speaker Askey: Is there further discussion?

. . . There being no further discussion, a vote was taken on the amendment, and the amendment was lost. . . .

Speaker Askey: The amendment is lost. The amendment as first proposed, which is that the change of the word "Director" to "Trustees" will be the only change in number 7. Is there further discussion on that amendment?

. . . The question was called for, the motion was put to a vote and was carried. . . .

Speaker Askey: It is carried as amended.

Dr. Delprat: Now we come to section number 8, in regard to the income level. The committee recommends the adoption of section 8 as stated. I so move.

. . . The motion was seconded. . . .

Speaker Askey: Is there discussion on that?

Dr. Ernest W. Page (Alameda County): It was probably the intention of the committee to change that $3,000 upper income level for those with dependents at the family income level but inasmuch as it does not state so, I would propose an amendment to insert "family" so that it might read that the upper income level of fee-for-service be established at $2,400 for an individual without dependents and $3,000 annual gross family income for an individual with dependents.

Speaker Askey: Is there a second to that amendment?

. . . The motion was variously seconded. . . .

Speaker Askey: Is there discussion on that—the addition of the world "family"? This is an amendment.

. . . There being no discussion, the motion was put to a vote and the amendment was carried. . . .

Speaker Askey: It is amended. Is there further discussion on the motion?

. . . The question was called for. . . .

Speaker Askey: The question is called for. The question is on the motion as amended.

. . . The motion was put to a vote and it was carried. . . .

Speaker Askey: The motion is carried as amended.

Dr. Delprat: We come now to number 9.

The committee has studied section number 9 and recommends its adoption as stated in the *Bulletin*.

Dr. Cline: I second the motion.

Speaker Askey: It has been moved and seconded that this section be adopted as stated in the *Bulletin*. Is there discussion?

Dr. Peter Blong (Los Angeles County): A point of information. Does not the committee mean hospital service must be on a state-wide basis and integrated with medical service rather than synchronized with medical service?

Speaker Askey: What is the interpretation of the committee on that?

Dr. Delprat: I think that is the interpretation the committee had in mind. We will stand corrected.

Speaker Askey: We will take it then that the committee's interpretation will be "integrated" instead of "synchronized," unless there is some objection. Is there discussion?

. . . There being no discussion, the question was called for, the motion was put to a vote and it was carried. . . .

Speaker Askey: It is adopted.

Dr. Delprat: The committee studied section number 10 and recommends its adoption as stated in the *Bulletin*. I so move.

Dr. Shephard: I second the motion.

Speaker Askey: Is there any discussion on the adoption of this point number 10?

Dr. Doughty: There is just another way of reducing your administrative expense by adding another administrative cost. We should have learned that the California Medical Association doesn't learn very much from spending money for surveys and I think, even if we spent $50,000 for extra auditors, it will not be a reduction of administrative expense and will not be of any advantage whatsoever.

Speaker Askey: Is there further discussion on the motion to adopt number 10?

. . . There being no further discussion, the motion was put to a vote. . . .

Speaker Askey: The Chair believes that number 10 is lost.

Dr. Delprat: We come now to number 11.

. . . A standing vote was called for on the previous motion. . . .

Speaker Askey: The Chair has already ruled. Is there a motion?

Dr. Chandler: I move we re-consider.

Speaker Askey: Is there a second?

Dr. Shephard: I second the motion.

Dr. Cline: I appeal from the ruling of the Chair.

Speaker Askey: There is an appeal from the ruling of the Chair.

Dr. Hoffman: Will the Chair poll Dr. Chandler and ask him how he voted, in the affirmative or the negative?

Speaker Askey: How did you vote?

Dr. Chandler: I voted for it.

Speaker Askey: He is in order.

A Member: The Chair did not rule. The Chair said, "I believe it is lost" and didn't say "It is so ordered."

Speaker Askey: You are right. I did not announce it. Do you wish to appeal from my ruling?

There is call for a division on the vote. All of those in favor of the motion to adopt number 10 please rise.

. . . A rising vote was taken on the motion. . . .

Speaker Askey: The motion is carried, 74 to 67. You will proceed.

Dr. Delprat: We come now to number 11.

The Reference Committee has studied number 11 and recommends it be adopted as written in the *Bulletin.* I so move, Mr. Chairman.

Dr. Donald: I second the motion.

Speaker Askey: Is there discussion?

Dr. C. Glenn Curtis: In discussing number 11, I feel, as a member of the Board of Trustees of C.P.S., and also as a Delegate of Orange County, that we should have some business men on the Board of Trustees. I think we should have these business men just as soon as we are able to handle them. I do not feel that C.P.S. is on a sound enough basis at the present time to bring in four outside men. I would like to offer an amendment to the motion that we have two men added this year and if you want two more next year, all right, but let us make the amendment to read that we add two men who are not Doctors of Medicine, who are business men this year.

Speaker Askey: There is a motion to amend by substituting the word "two" for "four." Is there a second to the amendment?

A Member: I second the motion.

Speaker Askey: It is now open for discussion.

Dr. William L. Bender (San Francisco): It strikes me as being quite inconsistent when the Chandler Committee, on the one hand, insists on the reduction of the operating expenses, the administrative expense, and, on the other hand, adds a very considerable item to the cost of operating the system.

In the first place, I should like to object to that inconsistency. Secondly, I would like to know what would be the additional cost to the system if number 10 and number 11 are adopted.

Speaker Askey: Is there anyone who can answer that question? I think that would be difficult to answer. It would depend on what we required. Is there anybody who can answer that? Dr. Chandler!

Dr. Chandler: I am not sure I can answer it with authority but I can certainly give you the opinion of the committee in making this recommendation.

First, concerning number 10, we were unable to find at the time we submitted these recommendations the report of any survey that we feel was comprehensive by a competent group that was available to us. Granted that there have been several studies made, and there were at least two that were in process of being made and we were advised that at least one, and I believe both of them, had been completed, but the reports were not available to our committee. Now it is my belief that number 10 could be executed undoubtedly by receiving or having access to the surveys that are now completed and which our committee do not have. I doubt very much if it is going to cost C.P.S. anything to have available such a survey including business administration, actuarial procedure and so forth. I may be wrong and if Dr. Goin were here maybe he could answer that question.

As to number 11, as to the increase in the size of the Board of Trustees, and the inclusion of four—and I don't know why we thought of four instead of three, five or two—but a small number of the Board of Trustees to be composed of recognized, experienced nonmedical business administrators who are trained and experienced in the business of evaluating their own procedure, financial reports and recommendations from their own administrators, would not be rude and insulting to our present members of the Board of Trustees of C.P.S. I have heard two of them say they did not know how to read an operating or a financial statement. I am not surprised. I don't know how to read one. I don't know why doctors should be trained or experienced in that sort of thing but these are business men, outside of medicine, whom the committee believed would be a help to the Board, not a hindrance, and it would really be helpful to the Board to have that kind of brains on the Board purely from a business administrative point of view. Maybe we are wrong. Thank you.

Speaker Askey: Dr. Madeley!

Dr. Madeley: I could visualize the time when California Physicians' Service has a membership of one million and the entire profession of the State is perfectly satisfied with its procedures and the fee schedule is adopted and it is paying a full par unit value; when it won't make any difference who sits on your Board, whether they be lay, doctors, or what-not.

At the present time there is still considerable work to do in regard to professional relationships. You should be surprised how much time is taken up in your Trustee meetings in trying to solve how we can sell the doctors this idea; how can we get complete professional coöperation in this state-wide plan; how much of the time is taken up on purely medical matters of the patient-doctor relationship; how much of the time is taken up in trying to establish how much we can afford to pay for a certain medical procedure. I don't know any laymen, in the course of getting this program adopted, who wouldn't go home and question in their own minds, do these doctors know what it is all about; do these doctors in the profession know what in the world they are trying to do.

I can say I certainly would like to see labor and lay people and industry and everybody represented in this fine organization, once it gets on a good, sound track. Let us doctors work the thing out as doctors until we get it going.

Speaker Askey: Is there further discussion?

Dr. Donald: Mr. Speaker, may I tell Dr. Madeley how we can get the confidence of the doctors in the Board of Trustees to a greater degree? That is put on men who are trained in business administration and not sit and wonder about how your business is going to be run. If you have on your board of directors trained men, not in cutting out an appendix or diagnosing histoplasmosis, but in diagnosing financial returns and telling you when you have got to raise your premium, which you can do and have done, 33 per cent, and not lose a half of 1 per cent of your subscribers, men who can tell you when you are solvent and when you are not; I can tell you you will have more confidence in what you are trying to do from doctors than by molly-coddling yourselves. (Applause.)

. . . The question was called for. . . .

Dr. Donald D. Lum (Alameda County): As a member of the Board of Trustees of C.P.S., I agree with Dr. Madeley. We do not need the doctors. I think there is still room for advice from business men on the Board. We really think that C.P.S. must be controlled by the medical profession. It still would be but we would have the advantage of business advice during the period of development that we are going through.

Speaker Askey: Is there further discussion on the amendment which is to change the word "four" to "two"?

. . . The question was called for. . . .

A Member: That would also change "eleven" to "fifteen."

Speaker Askey: It wouldn't change that.

Dr. Doughty: I move to amend the amendment by striking out the word "fifteen" and substituting "thirteen."

Speaker Askey: Is there a second to that?

Dr. Turnbull: I second the amendment.

Speaker Askey: Is there discussion on the amendment?

If not, all of those in favor of the second amendment, which changes the word "fifteen" say "aye"; opposed "no."

. . . A vote was taken on the amendment.

Speaker Askey: It is lost. The word "fiifteen" remains. We are back on the amendment which merely changes the word "four" to "two."

. . . The question was called for, the motion was put to a vote and it was not carried. . . .

Speaker Askey: The motion is lost. The motion before you is to accept paragraph number 11 as it stands.

. . . The question was called for, the motion was put to a vote and it was carried. . . .

Speaker Askey: It is carried and so ordered.

Dr. Delprat: This brings us down to number 12. The committee conceived that 12 and 13 are very similar import and these two items were combined into a substitute, reading as follows:

> That the Board of Trustees of California Physicians' Service conduct, direct and control the affairs of the California Physicians' Service, employing such executives, directors and assistants as may be necessary, and delegating such authority and duties to each as sound business principles dictate.

I move the adoption of this portion of it.

Speaker Askey: The motion is to adopt number 12 and 13 as amended by the substitution just read to you.

Dr. Dewey: I will second the motion.

Speaker Askey: Is there discussion on this?

. . . There being no discussion, the motion was put to a vote and it was carried. . . .

Speaker Askey: The motion is adopted as amended.

Dr. Delprat: We come now to paragraph 14. The committee recommends its adoption as written in the *Bulletin.* I so move, Mr. Chairman.

Dr. Shephard: I so second.

. . . There being no discussion, the question was called for, the motion put to a vote and it was carried. . . .

Speaker Askey: It is carried.

Dr. Delprat: Number 15. The committee recommends the adoption of this recommendation as published in the *Bulletin.* I so move.

Dr. Dewey: I will second the motion.

Speaker Askey: Is there any discussion?

. . . There being no discussion, the motion was put to a vote and it was carried. . . .

Speaker Askey: It is adopted.

Dr. Delprat: In regard to number 16, the committee wishes to amend this paragraph by inserting on the third line after the words "voluntary systems of prepaid medical care," the words "approved by the Council"; otherwise, it reads exactly the same. I move this be adopted.

Dr. Donald: I second the motion.

Speaker Askey: Is there discussion?

. . . There being no discussion, the question was called for, the motion was put to a vote and it was carried. . . .

Speaker Askey: It is carried.

Dr. Delprat: I move that the Report of Reference Committee Number 1 as amended during the evening be adopted and approved as a whole.

Dr. Curtis: I will second the motion.

Dr. Cline: A point of information. What about Report of the Council?

Speaker Askey: That comes under Committee Number 2.

The motion is on the adoption of the report as a whole as amended. Is there any discussion?

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

Dr. Delprat: Mr. Speaker, I move that the report just accepted of Reference Committee Number 1 as amended be forwarded to the meeting of the Administrative Members of the California Physicians' Service.

Dr. Grogan: I second the motion:

. . . The motion was put to a vote and it was carried. . . .

Speaker Askey: It is so referred and at this time the Chair will declare a recess of the House of Delegates to last while the Administrative Members of the C.P.S. meeting is in progress, at the end of which time we will again take up our meeting.

We will turn the meeting over at this time to Dr. Goin.

. . . The House recessed, and following the recess, the Administrative Members of C.P.S. were in session. . .

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(The House of Delegates, together with elected Administrative Members, then sat as the Administrative Members of California Physicians' Service. Minutes of this meeting will appear in the next issue of this publication.)

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Post-Recess Meeting of the C.M.A. House of Delegates

The House of Delegates re-convened, after recess, immediately following the meeting of the Administrative Members of California Physicians' Service, at 10:45 P.M., Thursday, May 9, 1946, Vice-Speaker Alesen calling the meeting to order.

Vice-Speaker Alesen: We will now hear the report of Reference Committee Number 2.

Report of Reference Committee No. 2

E. T. Remmen (Chairman): Mr. Speaker and Members of the House of Delegates: Your Reference Committee has carefully considered the *Report of the Council* and the *Reports of the Secretary-Treasurer* and *Executive Secretary* of the California Medical Association as published in the *Pre-Convention Bulletin* and, in addition, a supplementary report submitted by the Council. It has also considered the reports of the *Component County Medical Associations* as published. If members of the House will turn to Page 9 of the *Pre-Convention Bulletin* it may expedite proceedings.

1. *Report of the Council.*

Sections 1 to 6 inclusive are narrative in character, apparently require no comment, and are approved by your committee. Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

Section 7. The Council suggests that the thanks of the Association be extended by the House of Delegates to the State and County Committees who have served so faithfully in the work of Procurement and Assignment. Our particular gratitude is due to the late Dr. Edward M. Pallette and to Doctors Harold A. Fletcher, William H. Kiger and Clarance G. Toland. Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded, it was put to a vote and unanimously carried. . . .

Section 8. At the last Annual Session, the House of Delegates directed that an *Advisory Planning Committee* be created. This committee, now familiarly and affectionately known as the "Super-Drooper Committee," has included in its membership Messrs. John Hunton, Stanley K. Cochems, Benjamin Harrison Read, Howard Hassard, Esq., Rollen Waterson and Frank J. Kihm, all well and favorably known to members of this House. Their recommendations and studies have been carefully prepared, and are well worth-while. The committee has entirely justified its formation and, in the opinion of your Reference Committee, should be continued. Mr. Speaker, I move the adoption of this portion of the report.

Dr. Robert E. Grogan: I second the motion.

. . . The motion was put to a vote and unanimously carried. . . .

Section 9. Attention is invited to the 1946 Annual Session of the American Medical Association, which will be held in San Francisco during the first week in July. The San Francisco County Medical Society has again undertaken the heavy responsibility of acting as host to the visiting delegates and physicians. The San Francisco Society is deserving of our gratitude for bringing this important meeting to the Coast.

Section 10. The Council has expressed appreciation of the services rendered to the California Medical Association by members of the Woman's Auxiliary. The Auxiliary's new publication, *The Courier*, should do much to increase the efficiency of the organization, which is becoming increasingly valuable to us. Your committee recommends that the House of Delegates join in the Council's expression. Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

Section 11. The Council has recognized the fact that if an adequate history of the founding and growth of the California Medical Association is ever to be written, it must be done now, before such records as still exist are hopelessly lost, and while men whose memories cover a large span of its existence are still living. Recognizing that no person is as well qualified by experience, interest and temperament to do this as is our beloved George H. Kress, the Council has, by resolution, designated him Honorary Historian.

Your Reference Committee heartily concurs in the eminent propriety of this action and further recommends that the Council provide the Committee on History of the California Medical Association, from time to time, such funds for incidental expenses as may be needed during the next few years, to permit Dr. Kress to carry this important work to a worthy and successful conclusion. Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

Section 12. The survey of California Hospitals now being carried on through the State Department of Public Health is of importance, and the Council asks the coöperation of all persons concerned. Your committee recommends approval. Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

Section 13. After forty-two years of devoted service to the county, state and national medical organizations, advancing years have brought our Secretary and Editor, Dr. Kress, to retirement from the life of intense activity which he has spent in loyal service to all of us. Dr. Kress has served his profession and the science of medicine more loyally than his own financial interests and he reaches the age of retirement, rich in a sense of duty well done and in the love of his fellows, but not in this world's goods.

The Council has adopted the following resolution:

Resolved, That the Council include in its Annual Report to the House of Delegtaes at the May, 1946, session, a recommendation that Doctor George H. Kress, presently the Secretary and Editor of the Association, be granted retirement status and that in recognition of his many years of continuous devoted service to the welfare of the Association, Doctor Kress be granted a pension for life, commencing at the end of the 1946 annual session, payable at the rate of $315.00 (Three Hundred and Fifteen Dollars) per month; provided, only, that in any month or months during which Doctor Kress accepts or undertakes any salaried position or positions carrying the aggregate compensation in excess of $15.00 (Fifteen Dollars) per month, then for such month or months, Doctor Kress shall not receive the monthly pension aforesaid.

Even if Dr. Kress had lost the brightness of eye, keenness of intellect and great good humor, which we have all long admired, he would still have earned well this token of our esteem.

Your committee heartily concurs in and asks this House of Delegates to approve the action of the Council. Mr. Speaker, I move the adoption of this portion of the Council's action.

. . . The motion was seconded and put to a vote. . . .

Dr. John Hunt Shephard (Santa Calara County): I wish to speak to this.

Vice-Speaker Alesen: The Chair has not announced the decision. You may do so and approach the rostrum, please.

Dr. Shephard: Members of the House of Delegates: I most heartily am in favor of this resolution except the last part. I have worked intimately in this Association with Dr. Kress for the past 25 years. I do not believe it is proper or fitting that in the event someone recognizes his unusual capacity and hires him for some other job that he should be deprived of what I consider is his just due from this organization.

I would like to offer an amendment in that if he accepts a position carrying an aggregate compensation in excess of $15.00 per month that whatever sum is in excess of the $15.00 a month from private employment that this sum be deducted from the $315.00 pension which we are paying him.

Dr. Cline: Mr. Speaker, this resolution of the Council took into account several factors. I don't believe the Council has any objection to the amendment presented but Dr. Kress will draw, and in the event of his death his widow will draw, Social Security which will make up the proportion of his total compensation. That, undoubtedly, is the plan as it is not permissible for a person to be gainfully employed at a rate greater than $15.00 a month. There was no desire on the part of the Council to limit Dr. Kress.

Vice-Speaker Alesen: I do not hear a second to Dr. Shephard's amendment and for that reason the Chair will rule it is lost. Do you now wish to vote upon the recommendation of the committee on this section? Is there any further discussion?

. . . There being no further discussion, the motion was put to a vote and it was carried. . . .

Vice-Speaker Alesen: It is carried and so ordered.

Dr. Remmen: Sections 14 to 18 inclusive. The activities of the Council recited in these sections meet with the approval of the committee and apparently require no special action by the House at this time, with the exception of the proposed amendment to the Constitution which would abolish the requirement that the Secretary-Editor be a Doctor of Medicine, upon which your committee expresses no opinion since the question is not properly debatable at this time.

The Council has proposed the following resolution to be introduced by the California Medical Association's delegation to the Convention of the American Medical Association:

Whereas, The medical profession in the United States is irrevocably opposed to compulsory health insurance and government control of the physician-patient relationship; but

The medical profession, however, whole-heartedly supports the national medical care program adopted by the Board of Trustees of the A.M.A.—a program calculated to bring prepaid medical care to the American people on a voluntary free enterprise basis; and

If government controlled medicine is to be prevented it is imperative that a united front of all business, agriculture, labor, veterans and other groups and organizatoins that are in favor of free enterprise and the American system be established immediately; and

The medical profession must take the lead in creating a united front and in the coördination of all such groups and organizations to the end that an effective campaign be prosecuted with vigor; and

It is likewise imperative that action be taken now—tomorrow may be too late.

Now, Therefore, Be It Resolved, (1) The A.M.A. immediately secure the most competent and experienced legislative representative that can be found to represent the Association at Washington, D. C.—instead of the skeleton set-up now sometimes used.

(2) That such representative be given complete authority and full coöperation, financial and otherwise, in the carrying out of the policies of the A.M.A., including the establishment of a united front against government controlled medicine.

(3) That the most competent and outstanding public relations counsel that can be found in the United States be employed immediately to bring to the American public the real story of medicine and the cost of medical care.

(4) That the national medical care program adopted by the House of Delegates of the A.M.A. and by the Board of Trustees of the A.M.A. immediately be implemented by sufficient appropriation of funds of the A.M.A. to permit the program to be established by those state medical societies that have not as yet been able to permit a real nationwide furthering of existing and flourishing prepaid medical care plans.

(5) The foregoing plan of action should replace all of the existing organizations that are endeavoring to do legislative work on a national scale.

The committee concurs in the principles set forth in the resolution. Mr. Chairman, I move the adoption of of this portion of the report. (See page 405.)

. . . The motion was seconded, put to a vote and unanimously carried.

Dr. Remmen: The Council has approved a proposed study of child health services which is to be made by the American Academy of Pediatrics for the purpose of gathering necessary facts from which future plans can be developed and to determine the quality and extent of such services now available. It is believed by the Academy that physicians are in the best position to develop constructive plans for medical service to children. The program has been approved by the American Medical Association. Your committee approves of the Council's action in this matter. Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded, put to a vote and carried. . . .

Dr. Remmen: Mr. Speaker, I move the adoption of the *Report of the Council* as a whole.

Dr. Grogan: I second the motion.

. . . The motion was put to a vote and it was carried. . . .

2. *Report of the Secretary-Treasurer.*

The reports of the Secretary-Treasurer, including the 1945 budget, and the Report of the Certified Public Accountant, Hood and Strong, of San Francisco, have been carefully studied by the Committee. Expenditures last year totaled $235,532.18 as compared with an original budget estimate of $116,588.00, and as compared with total expenditures in 1944 of $134,809.90. Most of this increase was due to heavy expenses incident to the defeat of strong efforts to inflict compulsory health insurance upon the people of California. Funds were also applied to the furtherance of California Physicians' Service, and to a well planned campaign of education of the public in matters of health insurance and other pertinent subjects. Although a detailed report of expenditures has not been published, your Reference Committee have satisfied themselves as to the nature and purpose of the expenditures and as to the necessity therefor. All vouchers and accounts covering such expenses have been reviewed and found to be in order by Messrs. Hood and Strong, Certified Public Accountants.

It is the opinion of the committee that all expenditures by the Council have been essential. The attention of the House is called to the financial statement on Pages 13, 14, 15, 16 and 17 of the Annual Session Report. Your committee approves the report of the Secretary-Treasurer. Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

3. *Report of the Executive Secretary.*

The attention of the House is invited to Section 3 of the Executive Secretary's Report on Page 17. It is gratifying to note the increase in advertising revenue earned by California and Western Medicine. It is recommended by your committee that the Council be requested to appoint a committee on advertising policy with whom the Executive Secretary, in his capacity as business manager of the Journal, may consult concerning the suitability of proposed advertising.

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

Dr. Remmen: Attention is called to the recommendation of the Executive Secretary that arrangements be made as soon as possible for the establishment of group malpractice insurance coverage throughout California. The committee recommends that the Council study the advisability of such a program.

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was put to a vote and it was unanimously carried. . . .

Dr. Remmen: The committee also approves the Executive Secretary's recommendation that legislation be sought to strengthen the Industrial Accident Commission in the matter of establishing, enforcing and reviewing medical and surgical fee schedules and preventing rebates, fee cutting, fee splitting and other evils long associated with this work.

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

Dr. Remmen: Mr. Speaker, your Committee commends the work of the Executive Secretary during the past year and approves his report.

I move the adoption of this portion of the report.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

4. *Report of the Editor.*

The committee invites attention to the Report of the Editor, Dr. George H. Kress, who has edited the official journal since 1927, is now retiring. The committee desires to express its appreciation of Dr. Kress' labors which have brought California and Western Medicine into the forefront of state medical publications, and extends to him every good wish in the historical work which he is to undertake.

Mr. Speaker, I move the adoption of this portion of the report.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

5. *Reports of County Medical Societies.*

The committee has read with interest the reports of the secretaries of the component county societies published in the *Pre-Convention Bulletin.* The secretaries speak of efforts made by their societies to aid members returning from service to secure office space, hospital facilities, and in some instances financial assistance to reëstablish themselves in practice. There is a general expression of deep appreciation of the great service rendered to the nation and to ourselves by our military members, and the efforts made by the county societies to assist them are most commendable.

Los Angeles County has inaugurated a system of lectures and interviews required of each applicant for membership, which is known as an indoctrination program. About 250 applicants have so far taken this course. It has met with the general approval of applicants for membership who feel they have acquired much information of value. At the same time, it has given officers and committeemen of the Association an opportunity to become acquainted with new applicants and to interest them in society activities, which would not otherwise be possible in so large a society. The indoctrination program is attracting nationwide attention. The Los Angeles County Medical Association is making plans to enlarge its headquarters building.

The Alameda County Society during the year employed a full-time Executive Secretary, Mr. Rollen Waterson. The society has undertaken many new activities, which are described in the report of Dr. Dorothy Allen, Secretary.

The San Francisco County Medical Society, likewise appointed an Executive Secretary, Mr. Frank J. Kihm, in September, 1945. An interesting activity of the San Francisco Society is that of the Irwin Blood Bank.

Your committee is informed that the Santa Clara County Society has also recently employed an Executive Secretary.

It is the opinion of your committee that the component county societies are, with few, if any, exceptions, in a healthy and flourishing condition.

Mr. Speaker, I move the adoption of their reports.

. . . The motion was put to a vote and it was unanimously carried. . . .

DR. REMMEN: Mr. Speaker, I move the adoption of this report as a whole.

. . . The motion was seconded. . . .

SPEAKER ASKEY: You are voting upon the adoption of the Report of the Reference Committee as a whole. Is there any discussion?

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: It is carried and so ordered.

Next will be the Report of Reference Committee Number 3, Dr. Dwight L. Wilbur, Chairman. Dr. Wilbur!

Report of Reference Committee No. 3

DR. DWIGHT L. WILBUR (Chairman): Mr. Chairman and Members of the House of Delegates: The hour is late. I would like to move that the By-Laws be set aside so that we may avoid reading of each resolution.

SPEAKER ASKEY: That has to be done at the start of the meeting.

I wonder if it would be possible to have the resolutions passed among the members of the House.

. . . Copies of the resolutions were distributed to the Members of the House of Delegates. . . .

DR. WILBUR: I think it is very appropriate at this time that we thank the members of the secretary's staff who helped in the preparation of these resolutions and copies of the report for you.

The members of Reference Committee Number 3 have been Doctors C. J. Berne, Los Angeles; Doctor A. E. Moore, San Diego and myself. In considering all matters of business referred to it, the committee has consulted with many members of the House of Delegates, of the Council of the C.M.A., of the Board of Trustees of C.P.S., and officers of the C.M.A., and wishes to submit the following report:

Constitutional Amendment:
Proposed Amendment to C.M.A. Constitution—Re: Ex-officio Members of Council

The only change in the Constitution which this amendment includes is that the Vice-Speaker of the House of Delegates becomes an ex-officio member of the Council.

Your committee recommends that this amendment be adopted.

. . . The motion was seconded and, there being no discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: The Amendment to the Constitution is adopted. Proceed.

DR. WILBUR:

Resolution No. 1.—Re: Approval of "California Plan"

This resolution was introduced by the San Francisco delegation. It has been carefully considered by the committee which approves of its adoption as submitted.

May I say that the approval of this resolution does not necessarily mean that the House approves of the "California Plan" but approves of the resolution concerning the California Plan.

I move the adoption of this section of the report.

SPEAKER ASKEY: Is there discussion on this?

. . . The motion was seconded, put to a vote and unanimously carried. . . .

SPEAKER ASKEY: It is adopted.

DR. WILBUR:

Resolution No. 2.—Re: Legislative Committee

This resolution was introduced by the San Francisco delegation and is approved by the Reference Committee which wishes to add its appreciation of the excellent work done by the Legislative Committee during the past year.

The committee recommends the adoption of this resolution.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

DR. WILBUR:

Resolution No. 3.—Re: Physician Membership in C.P.S.

This resolution was introduced by the San Francisco delegation. The committee approves of this resolution and recommends its adoption.

I move the adoption of this section of the report.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

DR. WILBUR:

Resolution No. 4.—Re: Membership in C.P.S. of Physicians, Their Families and Employees

This resolution was introduced by the San Francisco delegation. The committee approves of this resolution and recommends its adoption. I so move.

DR. CARR: I second the motion.

. . . There being no discussion, the motion was put to a vote and unanimously carried. . . .

SPEAKER ASKEY: It is adopted.

DR. WILBUR:

Resolution No. 5.—Re: Legalizing of Willing of One's Body for Designated Reconstructive Purposes

This resolution was introduced by the San Francisco delegation. After careful consideration, the committee has slightly amended the resolution without changing significantly the meaning of it and submits the following amended resolution.

WHEREAS, The technique of a corneal transplantation in the science of eye surgery, and the use of cartilage implants for plastic repair in plastic surgery have reached a high level of technical attainment, and

WHEREAS, There is a growing civilian need and there are now some thousands of wounded veterans residing in veteran hospitals in the State of California and elsewhere, many of whom require plastic surgery, and

WHEREAS, Operative procedures in many of these cases are now at a standstill because of lack of these fundamental materials for their plastic reconstruction, and

WHEREAS, The ultimate restoration of these veterans and civilians to normal life may not be completed until such materials are available, Be It, Therefore

Resolved, That the California Medical Association instruct its legislative committee to promote constructive legislation to legalize the willing of either a whole or a part of one's body to a recognized institution for subsequent use of any whole or parts of that body for designated reconstructive purposes.

Your committee moves the adoption of this amended resolution.

. . . The motion was seconded. . . .

SPEAKER ASKEY: Is there any discussion? If not, the question goes before you.

. . . The question was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: It is adopted as amended.

DR. WILBUR:

Resolution No. 6.—Re: Formation of Section on General Practice of the California Medical Association

This resolution was introduced by Doctor Eric A. Royston of Los Angeles. A keen and widespread interest in the organization of sections on general practice in the A.M.A., the Los Angeles County Medical Association and other organizations indicates clearly the great need for the formation of a Section on General Practice of the C.M.A., and the committee heartily endorses and approves of this resolution.

I move the adoption of this section of the report.

DR. ROYSTON: I second the motion.

SPEAKER ASKEY: Is there any discussion?

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: It is adopted.

DR. WILBUR:

Resolution No. 7.—Re: Limitation on Annual Dues

This resolution was introduced by Doctor J. M. De Los Reyes of Los Angeles. The committee wishes to point out that Article V, Section 11 of the Constitution states that "The House of Delegates at its Annual Session shall fix the amount of the annual per capita assessment of dues upon active members." Consequently, it is the opinion of the committee that this House of Delegates cannot fix the annual dues for more than one year, that since to do so would require an amendment to the Constitution, this resolution should not be approved and be not adopted.

I move the acceptance of this portion of the report.

SPEAKER ASKEY: You have heard the motion, that the recommendation of the committee be accepted. Is there a second?

DR. DOYLE: I second the motion.

SPEAKER ASKEY: Is there discussion?

There being no discussion, the motion was put to a vote and it was carried. . . .

SPEAKER ASKEY: It is adopted. That is, the committee's report is adopted and this resolution is lost. Will you proceed?

DR. WILBUR:

Resolution No. 8.—Re: Utilization and Development of Personnel from Medical Corps, Army and Navy, for Medical Students, Technologists and Medical Assistants

This resolution was introduced by Doctor William Makaroff from Sonoma County. The committee approves of this resolution and recommends its adoption.

I move the adoption of this section of the report.

DR. GREEN: I second the motion.

SPEAKER ASKEY: Is there discussion?

. . . There being no discussion, the motion was put to a vote and it was carried. . . .

SPEAKER ASKEY: It is adopted.

DR. WILBUR:

Resolution No. 9.—Re: Postgraduate Facilities Sponsored By and With the Coöperation of the Committee on Postgraduate Activities of the C.M.A.

This resolution was introduced by Doctor William Makaroff of Sonoma County. The committee has given much consideration to the needs stated in this resolution but recognizes the fact that medical schools and hospitals which have been designated for instruction and training in the larger metropolitan centers have been under heavy burdens during the war and do not at present have adequate facilities to develop satisfactory continuous courses in instruction for the individual postgraduate student. The Reference Committee is of the opinion that the Committee on Postgraduate Activities of the C.M.A. could perform a very useful service in meeting the immediate need.

Your committee further is of the opinion that there is a great need in the C.M.A. for a long-time program in postgraduate instruction in the scientific aspects of medicine. The establishment of continuation postgraduate courses in instruction similar to those already established in some states would raise considerably the level of practice of medicine throughout California.

Your committee therefore presents this substitute resolution.

Therefore Be It Resolved, That the Committee on Postgraduate Activities of the C.M.A. be instructed to proceed as rapidly as possible with plans toward the establishment of postgraduate activities throughout the State in coöperation with the medical schools and larger hospitals, and, be it further

Resolved, That in the establishment of these activities there shall be kept in mind the particular needs of physicians who have been in the armed forces and those who have been in active civilian practice during the war and unable to devote appreciable time to postgraduate studies, and, be it further

Resolved, That the Council of the C.M.A. be instructed to appoint a special committee of the C.M.A. to study fully the matter of establishing with the coöperation of the medical schools in the State, Postgraduate Continuation Courses of Instruction in all the scientific aspects of medicine for members of the C.M.A., and to report the findings of the special committee to the next meeting of the House of Delegates of the C.M.A.

The committee recommends the adoption of this substitute resolution.

. . . The motion was variously seconded. . . .

SPEAKER ASKEY: Is there any discussion? If not, the motion is before you on the adoption of the substitute resolution.

. . . A vote was taken on the substitute resolution and it was carried. . . .

SPEAKER ASKEY: It is carried.

DR. WILBUR:

Resolution No. 10

This resolution was referred by the Speaker of the House of Delegates to Reference Committee Number 1.

Resolution No. 11.—Re: Doctor Kress

This resolution was introduced by Doctor C. Max Anderson of Los Angeles County. The committee approves of this resolution and recommends its adoption.

I move the adoption of this section of the report.

. . . The motion was seconded, put to a vote and unanimously carried. . . .

DR. WILBUR:

Resolution No. 12.—Re: Fees for Internists and Other Non-Surgical Specialists

This resolution was introduced by Dr. William L. Bender of San Francisco County. After careful consideration and discussion, your committee has slightly amended this resolution to read as follows:

WHEREAS, Special service and skills are nearly adequately compensated in established fee schedules of most voluntary prepaid medical plans, and

WHEREAS, It is universally agreed that fees paid under *these* plans to internists, and *other non-surgical specialists,* for special services are wholly inadequate, and

WHEREAS, Increasing numbers of people are and will be receiving medical care under such plans, and

WHEREAS, The net effect of these factors has been a critical problem recognized by the California Society of Internal Medicine, Now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association approve the principle that fees for such special services of internists and other non-surgical specialists shall be increased to a level already apportioned to physicians who perform special services.

The old wording which has been changed is that part in italics.

I move the adoption of this section of the report.

DR. BAILEY: I second the motion.

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: It is adopted as amended.

DR. REMMEN: I believe Resolution Number 11 should read, in the third paragraph, fifth line, "his great love for medical science."

SPEAKER ASKEY: The correction is made. Thank you, Dr. Remmen.

Proceed, Dr. Wilbur.

DR. WILBUR:

Resolution No. 14.—Re: The Activities of the Editor of the A.M.A .

This resolution was introduced by Doctor Edwin L. Bruck of San Francisco County. Your committee heartily endorses this resolution and recommends the adoption of it.

I move the adoption of this section of the report.

DR. CLINE: I second the motion.

SPEAKER ASKEY: Is there any discussion?

If not, the question is on the adoption of this section of the report which is before you.

. . . The motion was put to a vote and it was carried. . .

SPEAKER ASKEY: It is adopted.

DR. WILBUR:

Resolution No. 15.—Re: Approval of Plans for Group, Organization, Corporation or Individual Practice

This resolution was introduced by Doctor C. Kelly Canelo of Santa Clara County. The committee has very carefully considered the subject matter of the resolution and is of the opinion that the important points under consideration are first, the approval of certain principles regarding the organization and conduct of individual, group or corporation voluntary prepaid medical plans, and, second, that it is of great importance that the members of the C.M.A. be promptly informed of the official stand of the Association on the approval of such plans. Consequently, the Reference Committee wishes to substitute the following resolution:

Be It Resolved, That the C.M.A. approves the principles established by the Council on Medical Service and Public Relations of the A.M.A. for the organization and conduct of individual, group or corporation voluntary prepared medical plans, and, further, be it

Resolved, That the House of Delegates instruct the Council and Executive Committee of the C.M.A. in the future to survey all such plans proposed on a statewide basis and to promptly transmit their findings and recommendations to the individual members of the C.M.A. for rapid, effective statewide action.

Your committee recommends the adoption of this substitute resolution.

I move the adoption of this substitute resolution.

. . . The motion was seconded. . . .

SPEAKER ASKEY: Is there discussion?

DR. DELL T. LUNDQUIST (Santa Clara County): I wish to move an amendment to the resolution as proposed by the committee under line 2 of the resolution to strike out the words "on a statewide basis," to read:

Resolved, That the House of Delegates instruct the Council and the Executive Committee of the C.M.A. in the future to survey all such plans proposed and to promptly transmit . . .

and so forth.

SPEAKER ASKEY: Is there a second to that amendment?

. . . The motion was seconded. . . .

SPEAKER ASKEY: You will now vote on the adoption of the amendment. Is there any discussion?

. . . There being no discussion, the motion was put to a vote and it was carried. . . .

SPEAKER ASKEY: The amendment is adopted.

Now, the amendment as proposed by Dr. Wilbur, which you have just amended, is before you for adoption. If there is no discussion, the question goes before you on the adoption of the recommendation of the committee, the substitute amendment.

. . . A vote was taken on the adoption of the substituted resolution as amended, which was carried. . . .

SPEAKER ASKEY: It is adopted.

DR. WILBUR:

Resolution No. 16.—Re: Changing the Law Regarding Coroners

This resolution was introduced by Doctor Charles Galligan of Monterey County. The Reference Committee approves of this resolution and urges its adoption.

I move the adoption of this section of the report.

. . . The motion was seconded, put to a vote and carried. . . .

SPEAKER ASKEY: It is adopted.

DR. WILBUR:

Resolution No. 17.—Re: The Establishment of a Medical Examiners System

This resolution was introduced by Doctor Charles Galligan of Monterey County. The Reference Committee approves of this resolution and urges its adoption.

I move the adoption of this section of the report.

. . . The motion was seconded. . . .

DR. CARR: I would like to propose an amendment to this resolution to be added to the end of paragraph 5, the amendment to be the adding of the following words: "and where available to qualified pathologists."

DR. DONALD: I will second the amendment.

SPEAKER ASKEY: Is there any discussion on the amendment?

. . . There being no discussion on the amendment, a vote on the amendment was taken, and the motion was carried. . . .

SPEAKER ASKEY: The amendment is carried. There is now before you the motion to adopt this section of the report as amended. Is there discussion?

. . . There being no discussion, the motion was put to a vote and it was carried. . . .

SPEAKER ASKEY: It is adopted as amended.

DR. WILBUR:

Resolution No. 18.—Re: Medical Relations—Retrospect and Prospect

This resolution was introduced by Dr. D. T. Lundquist of Santa Clara County. The committee has given careful consideration to the contents of this resolution and has discussed at considerable length the matter of bringing up to date the Code of Ethics of the C.M.A. It is of the opinion that the objects desired in this resolution and by the committee can best be obtained by referring the whole matter to the Council of the C.M.A. for further reference to an appropriate committee. Consequently, the committee wishes to offer the following substitute resolution:

> WHEREAS, New methods of communication and new relationships in the medical-legal aspects of practice have developed in recent years, and
>
> WHEREAS, These developments require reconsideration of the principles of medical ethics, Now, therefore, be it
>
> *Resolved,* That the recodification of the Code of Ethics of the C.M.A. shall be given careful consideration and that this House of Delegates recommend to the Council of the C.M.A. that it refer this matter to an appropriate committee.

Your committee moves the adoption of this substitute resolution.

. . . The motion was seconded. . . .

DR. LUNDQUIST: I wish to offer an amendment to the resolution as modified by the committee; to insert at the end of the resolution "this proposed recodification for approval by the next annual meeting of the House of Delegates," and insert a second section as follows: "That the essence of this resolution again be brought before the House of Delegates of the A.M.A."

SPEAKER ASKEY: At which time do you mean; then or after the report?

DR. LUNDQUIST: After the next meeting.

SPEAKER ASKEY: Is the amendment seconded?

. . . The amendment was seconded. . . .

SPEAKER ASKEY: Is there any discussion before you vote on the amendment proposed by Dr. Lundquist?

. . . There being no discussion, the motion to adopt the amendment was put to a vote and it was carried. . . .

SPEAKER ASKEY: Now the question before you is on the adoption of the amended proposal as made by Dr. Wilbur's committee.

DR. REMMEN: I would like to propose another amendment: "that the recodification include suitable penalties for violation of the Code."

DR. BAILEY: I will second the amendment.

SPEAKER ASKEY: Is there discussion on the amendment?

. . . There being no discussion, a vote was taken on the amendment. . . .

SPEAKER ASKEY: The Chair is in doubt. We will take a standing vote.

DR. DOUGHTY: It wouldn't be within the province of any committee to recommend the penalty.

DR. REMMEN: A Code without penalties is worthless.

SPEAKER ASKEY: I thought it would be within the province of any committee to recommend anything. The carrying out of it would be the question. The point is not well taken.

All those in favor of the amendment please stand, and will you count them, Mr. Secretary?

. . . A standing vote was taken on the amendment with a vote of 43 to 45. . . .

SPEAKER ASKEY: The motion now before you is the motion of the committee to adopt the resolution as it has been amended by Dr. Lundquist.

. . . A vote was taken on the motion to adopt the recommendation of the committee as amended and the motion was carried. . . .

DR. WILBUR:

Resolution No. 19.—Re: Regional Meetings

This resolution was introduced by Dr. Richard O. Bullis of Los Angeles County. Your committee heartily endorses the subject matter of this resolution and wishes particularly to emphasize the advisability of strengthening the organization of the C.M.A. by having at frequent intervals conferences of the presidents and secretaries of the component county associations with officers of the C.M.A.

I move the adoption of this resolution.

DR. GREEN: I second the motion.

SPEAKER ASKEY: Is there any discussion?

. . . There being no discussion, the motion was put to a vote and it was carried. . . .

SPEAKER ASKEY: It is adopted.

DR. WILBUR:

Resolution No. 20.—Re: Pension for Employees of the C.M.A.

This resolution was introduced by Dr. Wilbur Bailey of Los Angeles County. Your committee has carefully considered the purposes of the resolution and is of the opinion that there are many advantages in establishing such a pension system for the employees of the C.M.A. However, the committee is of the opinion that that part of the resolution which has to do with submitting to a referendum of the membership of the C.M.A. the establishment of a pension plan or plans favored by the House of Delegates is not necessary. Consequently, the committee wishes to submit a substitute resolution as follows:

> *Be It Resolved,* That the House of Delegates of the C.M.A. is in favor of establishing a pension plan for the employees of the C.M.A., and, be it further
>
> *Resolved,* That the Council of the C.M.A. be instructed to investigate such a plan for the employees of the C.M.A.

Your committee recommends the adoption of this report.

DR. DEWEY: I will second the motion.

. . . The question was called for, the motion was put to a vote and it was carried. . . .

SPEAKER ASKEY: The amendment is adopted.

DR. WILBUR:

Resolution No. 21.—Re: The Proposed Initiative—"The Naturopathic Act"

This resolution was introduced by Dr. Wilbur Bailey of Los Angeles County. Your committee is of the opinion that every physician in California should be informed of the contents of this proposed initiative. Your committee approves of this informative resolution and recommends the adoption of it.

I move the adoption of this section of the report.

. . . The motion was seconded, put to a vote and carried. . . .

SPEAKER ASKEY: It is adopted.

DR. WILBUR:

Resolution No. 22.—Re: A Comprehensive Fee Schedule for C.M.A.

This resolution was introduced by Dr. J. Frank Doughty of San Joaquin County.

The committee has carefully considered the contents of this resolution and feels that at the present time it would be unwise to attempt to establish any fee schedule which could be interpreted as the official fee schedule of the C.M.A. It proposes, therefore, to substitute the following resolution:

> *Therefore, Be It Resolved,* That in the future the C.P.S. Veterans' Administration fee schedule be used as a basis for negotiating fee schedules with all other government agencies, and be it further
>
> *Resolved,* That the policy of the C.M.A. be that all such negotiations with government agencies be carried out through C.P.S.

Your committee recommends the adoption of this substitute resolution.

DR. DOYLE: I will second the motion.

SPEAKER ASKEY: Is there any discussion?

DR. LUNDQUIST: I think that we are setting up something that may be a little bit too inflexible, especially as to the Section on Anesthesiology. Yesterday you unanimously passed a resolution setting up a committee of five and adding to that committee of five, this delegate happening to be the only delegate in the Section at that time, and authorizing this committee to negotiate with the appropriate committees of the California Physicians' Service for adjusting inequities in the anesthesiology fee schedule. I think it would be very unwise to set up the present fee schedule of C.P.S. as an example for this Association at this time.

SPEAKER ASKEY: Dr. Wilbur!

DR. WILBUR: It might be well to call the attention of the House to the fact that the House has passed a part of the Chandler Committee report which states that the fee schedule of C.P.S. shall be revised. I think it will take care of the suggested amendment which Dr. Lundquist has to offer.

DR. LUNDQUIST: Biennial revisions are still rather remote from the present inequities of C.P.S. fee schedules, especially the veteran section of the C.P.S. fee schedule as far as anesthesiology is concerned. We believe a date two years from now is in order.

SPEAKER ASKEY: Is there further discussion on the adoption of this section of the report? Dr. Doughty!

DR. DOUGHTY: Mr. Speaker, it is just used as a basis for negotiation. It doesn't necessarily put it in effect. It is just used as a sort of basis.

SPEAKER ASKEY: Is there further discussion?

. . . There being no further discussion, the motion was put to a vote and it was carried. . . .

SPEAKER ASKEY: It is carried and adopted.

DR. WILBUR:

Resolution No. 13

This resolution was introduced by Dr. Edwin L. Bruck of San Francisco.

The committee has not had an opportunity to completely consider Resolution No. 13 and therefore has no recommendation to the House.

In explanation, I might say that it would be worth your while to turn to Resolution No. 13 which has to do with a warning label on certain types of drugs. As I briefly see the situation, this directive has been passed by the Commissioner on Foods and Drugs, Division of the Federal Security Agency, and there are certain advantages in having a warning label, particularly on such things as thyresol, which I understand this is particularly aimed at, and, on the other hand, this directive has the great disadvantage of not requiring labeling and I understand the dosage of the particular drugs which carry a working label so that drugs such as phenobarbital, the desiccated thyroid, sulfa drugs, thiouracil and other similar products which carry on each prescription bottle a warning label as to the drugs contained in the prescription and the amount of them.

So, without further information than what I have been given, the committee felt that it was in no position to recommend as to what you should do on this particular resolution.

SPEAKER ASKEY: Is there a motion to adopt the resolution as introduced by Dr. Bruck.

DR. F. M. POTTENGER, JR. (Los Angeles County): I will so move.

DR. KENNETH D. GARDNER (San Francisco): I will second the motion.

SPEAKER ASKEY: Is there any discussion on the motion?

DR. EDWARD B. DEWEY: The committee of the Council met with representatives of the State Pharmaceutical Association to consider this thing. They feel that there is more in this directive than appears so far; that it is a step in just more and more of a bureaucratic directive coming on down, which might be a good one, but many of them are bad and they want to have this thing stopped right now if it is possible.

As you can see, you get certain types of patients who think they can't take this drug or that drug or they go to a doctor and get a prescription; it is made up in the form of a pharmacists' package and it carries the label "pheno-barbital," a warning that the drug is habit-forming. Immediately there may be some distrust aroused and it was felt by the committee, in talking with the representatives of the Pharmaceutical Association that while there was some danger in drugs such as thyresol and so forth, if the doctors give them as prescription drugs they should know what they are prescribing and the dangers of them. If the doctors are not sufficiently acquainted with such drugs they should not be using them and we should take care of our own business and we shouldn't be having any directives coming down.

It was the feeling of the committee that we should back up these representatives of the Pharmaceutical Association and urge the adoption of this resolution.

SPEAKER ASKEY: Is there any further discussion?

. . . The question was called for, the motion was put to a vote and it was carried. . . .

SPEAKER ASKEY: It is adopted. Dr. Wilbur!

DR. WILBUR: Mr. Speaker, I move the adoption of the Report of the Committee as a whole.

SPEAKER ASKEY: You have heard the motion to adopt the Report of the Committee as a whole. Is there any discussion?

. . . There being no discussion, the motion was put to a vote and it was unanimously carried. . . .

SPEAKER ASKEY: Your Speaker wishes to call the attention of the House of Delegates to the great amount of work that your committees have done. You people who haven't sat on one of these committees don't really understand the vote of thanks that is really deserved by these men. Some of you men may be on these committees in the future.

I want to read the names of these men and I want you to give them a rising vote of thanks.

Reference Committee Number 1: Dr. Delprat, chairman; Dr. Regan and R. Freidell.

Reference Committee Number 2: Dr. E. T. Remmen, chairman; Brodie Stephens and E. W. Page.

Reference Committee Number 3: Dr. Dwight L. Wilbur, chairman; C. J. Berne and A. E. Moore.

I think we had better give them a rising vote of thanks for their work. (Rising applause.)

Is there any unfinished business to come before the House?

DR. KRESS: There is no unfinished business.

SPEAKER ASKEY: Dr. Mulfinger!

DR. CARL MULFINGER (Los Angeles): Resolution Number 6 calls for the election of officers for the proposed General Practice Section. I would like to ask the Chair if nominations for such officers is not in order?

SPEAKER ASKEY: It would be in order under new business. I will call for that next and give you an opportunity to bring that about.

This was my error. I had forgotten the most important part of unfinished business. I guess your chairman is getting a little tired, I am afraid. I am going to call on Dr. John Cline who will present the budget to you and recommend its introduction for next year.

DR. CLINE: I don't propose to bore you with some thirty odd items, one of which has ten sub-titles. The items of expense are rental, telegraph, telephone, postage, printing, stationery, et cetera, and I am just picking out the larger items as we go on. The salary of the Executive Secretary is $12,000.00; the Department of Public Relations is $50,000.00; the Department of Public Policy and Legislation, $16,000.00; the United Public Health League, $15,000.00, et cetera.

The budget, as we stated earlier, is dependent upon the dues. The Council has recommended that the dues be set at $100.00 per annum. I move that the House accept the recommendation of the Council and place the dues at $100.00 per annum.

Dr. Shepard: I will second the motion.

Speaker Askey: Is there any discussion?

. . . There being no discussion, a vote was taken on the motion and it was carried, there being one dissenting vote. . . .

Speaker Askey: It is carried.

If there is any new business, it may now be referred to this House.

Dr. Mulfinger, did you have a suggestion to propose for the General Practice Section?

Dr. Mulfinger: Mr. Speaker and Members of the House of Delegates: I nominate Dr. Eric Royston, Secretary Pro Tem, of the newly-created section. He has been the principal mover of such section in Los Angeles County which is functioning very well.

Speaker Askey: Are there further nominations for Secretary Pro Tem?

Dr. Donald: I move that the nominations be closed and that the ballot be cast.

. . . The motion was put to a vote and it was unanimously carried. . . .

Speaker Askey: It is unanimous and therefore carried. Dr. Royston is elected.

Is there further new business to come before the House?

Dr. Warren B. Allen (Alameda County): As President of Alameda County, I would like to ask the Delegates to support C.P.S. and as you approved the dues today, let's all get behind it one hundred per cent. (Applause.)

Speaker Askey: There is one announcement I would like to make tonight. The Council of the California Medical Association will meet tomorrow morning at 7:30 for breakfast in Conference Room Number 6 and the newly-elected councilors will be there as well as the old members. I do not mean the ones that have been "ousted," but the new ones and the continuing ones.

At this time it is a great pleasure for your Speaker to introduce to you the President of the California Medical Association who will introduce to you your new officers for the succeeding year. Dr. Philip K. Gilman! (Applause.)

President Gilman: Members of the House of Delegates: It gives me extreme pleasure to introduce at this time the President, Dr. Sam J. McClendon of San Diego. (Rising applause.)

. . . Dr. McClendon assumed the Chair as President. . .

President McClendon: Mr. President, Members of the House of Delegates: Needless to say, I am deeply appreciative of this honor. It is an honor, the greatest that any medical man in California can receive. Also, needless to say, such an honor forces upon an individual certain obligations. Those obligations during this next year will be very difficult. If I can fulfill the obligations this year in any manner as befitting the President, I shall be very happy and I know with the unity of purpose this House of Delegates has shown tonight in its accomplishments during this past year and tonight, that we will get along all right. I have no fear of what may be said this time next year and I have no further speech to make. The hour is late. I know you don't want to hear from me tonight. Next year I may have something to say.

Dr. Gilman: At this time it gives me great pleasure, also, to present to this House of Delegates your President-elect, Dr. John Cline of San Francisco. (Rising applause.)

President-Elect Cline: I think you have already heard too much from me today.

Dr. Gilman: It gives me great pleasure to present a man who really does not need presenting, the Speaker of the House, Dr. Vincent Askey. (Rising applause.)

It gives me great pleasure to present to this House of Delegates your Vice-Speaker, Dr. Louis A. Alesen. (Rising applause.)

Speaker Askey: There is one more thing your Speaker was very remiss in and that is why I didn't say anything when you gave me that ovation. I forgot to ask you to give thanks to another committee which spent even more time than the Reference Committees and that is the famous Chandler Committee. I think we ought to give them a real hand. (Rising applause.)

We have just one or two more things for you tonight. We will now have our Immediate Past President, Dr. Lowell S. Goin, address you on a very important matter.

Dr. Lowell S. Goin: Mr. Speaker, Members of the House of Delegates: With the adjournment of this House, there will come to an end the term of your President, Dr. Philip Gilman, climaxing a long, useful and honorable career in this Association as a Delegate, a Councilor, as Chairman of the Council, President-elect and President of this Association.

In the ancient classical civilization the Greeks awarded to those victorious in games and battles a flower crown and wreath. We no longer award this token but we still revere and admire our leaders. As a symbol of the ancient flower wreath, it is my pleasure on behalf of the California Medical Association to present Dr. Gilman with this plaque for his permanent possession.

. . . Dr. Gilman was presented with a plaque. . . . (Applause.)

Dr. Gilman: Members of the House of Delegates: As I lay down the duties of the highest office in this Association which you so graciously honored me with a year ago, it is with mixed feelings. This completes my twenty-sixth year since I became Chairman of the Surgical Section of the County Society and during that time I have never been out of harness. During those years I have been able, I hope, in some small measure, to contribute to those things for which this Association stands. If I have been able to do so in the various positions to which I have been honored it is because the men with whom I was associated have been the most loyal, hard-working, sincere and honorable group of gentlemen with whom I could ever wish to be associated.

The duties of the incoming President will be so lightened in a similar manner and in that respect they will be even strengthened as evidenced by what he said tonight in reference to the complete solidarity, the complete union, the steadfast aim which has been evinced in this House of Delegates this evening.

I can look back and remember many, many occasions when there was sharp division; when it seemed impossible that we should ever arrive at any decision. Tonight, look at the difference. That is one of the happiest recollections which I will take with me. The other is this plaque which will serve to remind me that at some time in my existence I may have been of a little service to our great profession. Thank you. (Applause.)

Speaker Askey: There is one more, or two, things which we must do and we will proceed to do one of them at least. The Chair, unless we hear objection, will appoint the President, the Chairman of the Council and the Speaker of the House and the Secretary to edit the Minutes of this meeting. If I hear no objection, the committee is appointed.

Now, the last thing of business, except our adjournment, means this. I want to present to you for the ovation that he deserves our retiring Secretary who is now doing his last duty, the Secretary of this Association which he has served so long. I present Dr. George Kress. (Rising applause.)

DR. KRESS: Mr. Speaker and Members of the Profession: I need not tell you what a great pleasure it has been for me during these many years to have served with you and for you. I have been grateful beyond all measure that since 1907, when it became my honor to be elected a member of the C.M.A. Council, I have continuously served on this Council for practically 40 years as either an elected or an ex-officio Councilor.

I wish I could tell you all how deeply I appreciate everything you have done for me during these many years.

I hope that insofar as I, myself, have been concerned, my efforts to work with you and for you and to coöperate in furtherance of measures, principles and ideals we all love, that through such aid as I may have been able to render I may have been of service to you and to our profession.

Thank you all very, very much. I wish you to know I am deeply appreciative.

SPEAKER ASKEY: A motion to adjourn is in order.

. . . It was moved, seconded and carried that the House adjourn. . . .

. . . The meeting of the House of Delegates adjourned at 11:50 P.M. . . .

E. VINCENT ASKEY, *Speaker,*
GEORGE H. KRESS, *Secretary.*

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION: MINUTES*

Minutes of the Three Hundred Thirty-first (331st) Meeting of the Council of the California Medical Association

The meeting was called to order in Conference Room No. 8 at the Hotel Biltmore, Los Angeles, at 2:00 P.M., on Monday, May 6, 1946.

1. Roll Call:

Councilors Present: Philip K. Gilman, Chairman; Sam J. McClendon, E. Vincent Askey, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, Edwin L. Bruck, Sidney J. Shipman, E. Earl Moody, Edward B. Dewey, Walter S. Cherry, Dewey R. Powell, and George H. Kress, Secretary.

Present by Invitation: L. A. Alesen, Vice-Speaker; Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; E. T. Remmen, Chairman, Committee on Local Arrangements; John Hunton, Executive Secretary; W. M. Bowman, Executive Director of California Physicians' Service; Hartley F. Peart, Legal Counsel; Howard Hassard, Associate Legal Counsel; Stanley K. Cochems, Executive Secretary, Los Angeles County Medical Association; Rollen Waterson, Executive Secretary, Alameda County Medical Association; Frank Kihm, Executive Secretary, San Francisco County Medical Society; Joseph F. Donovan, Executive Secretrary, Santa Clara County Medical Society and Chester L. Cooley, Secretary, California Physicians' Service.

2. Minutes:

Minutes of the following meetings of the Council, the Executive Committee, and "Trustees of the California Medical Association" were submitted and actions taken approved:

(a) Council Meeting (330th) held in Los Angeles, February 1, 1946. (Printed in CALIFORNIA AND WESTERN MEDICINE, for April, page 254.)

(b) Executive Committee Meeting (197th) held in San Francisco, March 1, 1946. (Printed in CALIFORNIA AND WESTERN MEDICINE, for April, page 258.)

(c) "Trustees of the California Medical Association" Meeting (19th) held in Los Angeles, February 1, 1946. (Printed in CALIFORNIA AND WESTERN MEDICINE, for April, page 257.)

3. Membership:

(a) A report of the membership as of April 30, 1946, was submitted and placed on file. The membership roster showed distribution as follows:

Total number of members (civilian and military) listed for year 1946: 7,569.

Members in military service: 1,266.

Members returned from service: 1,020.

(b) On motion made and seconded, it was voted to reinstate 647 members whose 1946 dues have been paid since April 1, 1946.

(c) On motion made and seconded, Retired Membership was granted to thirty-three members, whose applications had been received in accredited form from their county societies.

(d) On motion made and seconded, Associate Membership was granted to eleven members whose applications had been received in accredited form from their county societies.

(e) Attention was called to a communication that had been received from the Shasta County Medical Society, which stated it was the intention of its members to refuse to pay dues for the current calendar year as levied by the House of Delegates at the 1945 Annual Session.

After discussion, it was voted that a letter be sent to the Shasta County Medical Society and also to each member thereof, calling attention to the provisions in the Constitution and By-laws of the C.M.A., whereby membership is automatically lost if dues are not paid by April 1st of any calendar year. It was also suggested that a copy of the by-law provision be inserted in the letters to be sent out as noted above.

(f) Concerning obligations of military members to pay dues, as per case brought up in the Los Angeles County Medical Association (case of H.E.D), it was felt that the matters referred to, were within the jurisdiction of the Los Angeles County Medical Association for adjustment.

4. Financial:

(a) A cash report as of May 1, 1946, was submitted.

(b) A balance sheet, as of April 30, 1946, was submitted.

(c) Report was made concerning income and expenditures for April and for four months, ended April 30, 1946.

On motion made and seconded, the above reports were received and placed on file.

5. Interim Appointments:

Council Chairman Gilman reported upon tentative appointments made since the last Council meeting on February 1, 1946. On motion made and seconded, it was voted that the appointments which follow be confirmed:

(a) Edwin L. Bruck, Lloyd E. Kindall, and John W. Green appointed on Committee on Blood Procurement Facilities, in relation to American Red Cross plans.

(b) John W. Cline, E. Vincent Askey, and R. Stanley Kneeshaw appointed as a special Committee on Editorial Policy, to bring in report to Council.

(c) Lloyd E. Kindall, E. Vincent Askey, and Walter S. Cherry appointed as a special Committee on Executive Secretaries to County Medical Societies, to bring in report to Council.

(d) John W. Cline, E. Earl Moody and Frank A. MacDonald appointed as Committee on Pensions for C.M.A. Employees, to bring in report to Council.

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* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

6. Report of the Council:

A preliminary discussion on whether additions should be made to the Report of the Council to the House of Delegates took place. No changes or additions were submitted.

7. Appointment of Committee on Committees:

The Council Chairman announced the appointment of a Council Committee to bring in nominations for vacancies on Standing Association Committees. The committee named included: Sidney J. Shipman, Chairman; Walter S. Cherry, and R. Stanley Kneeshaw.

8. California Physicians' Service:

Report was made for California Physicians' Service by Doctor Chester L. Cooley, Secretary, and Mr. William Bowman, Executive Director. Among items receiving comment were the following:

(a) A total of 1,028 new professional members had been added to the roster of C.P.S. physicians, bringing professional membership to more than 6,500.

(b) That the registration fee of $5.00 originally levied to provide an organization fund for C.P.S. had been discontinued so that new professional members could now enroll as C.P.S. physicians without payment of such fee.

(c) That the problems arising through the three hospitalization groups in California and in medical service groups such as C.P.S., continued to exist, and that it was hoped ways and means could be found for betterment.

(d) That the C.P.S. deficit of $279,144.21 existing Nov. 1, 1945, had been reduced to $137,912.66 as of April 30th, a reduction in four months of $141,231.55.

(e) That the beneficiary membership of C.P.S. now includes some 208,000 persons.

(f) That the commercial income of C.P.S. is now at the rate of approximately $3,344,000 a year.

(g) That the administration costs had been reduced so that they now average about 15.5 per cent, or a reduction of 4.5 per cent over previous year's operations.

(h) That the Veterans' Administration program has brought fees to C.P.S. physicians of $57,000 in April, 1946, and would probably total $125,000 in May. The statement was also made that if physicians everywhere coöperate, it might be possible in a few years to bring to them an income of from eight to fifteen million dollars per year from the V.A. contract.

9. Report of the Legal Department:

The matter of betterment of the fee schedule of the California State Compensation Fund received considerable discussion. Comment was made concerning conferences that had been held with executives of the State Compensation Fund and Industrial Accident Commission.

Legal Counsel Peart called attention to the fact that from year 1913, when the fee schedule was originated, there was no change until 1920, when a 25 per cent increase was authorized. However, from 1920 to 1942, no protests concerning the schedule of fees had been filed or placed on record by the Association.

Since 1942, many conferences had been held in efforts to bring about an improvement that would be in line with existing office, hospital, and living costs.

Reference was made to the study committee of some ten or more members that had been appointed by the Industrial Accident Commission on which there is only one single representative of the medical profession.

10. Cancer Commission:

Lyell C. Kinney, Chairman of the C.M.A. Cancer Commission, made a report on the plans that had been considered by the C.M.A. Cancer Commission. After discussion, it was voted that the following recommendations be approved by the Council:

Council of the California Medical Association,
San Francisco, California.
Gentlemen:

At the 1945 meeting of the House of Delegates the Cancer Commission was directed to investigate the problem of "detection clinics" and submit a report to the Council. The following report is the result of that study with certain recommendations:

The original project of periodic physical examinations to detect early cancer or pre-cancerous lesions was financed by a grant of the American Medical Association in 1938 made to Dr. Catherine MacFarland of the Women's Medical College of Philadelphia. The results of that project have been fully reported in the *Journal of the American Medical Association*, December 2, 1944. Similar projects have been successfully conducted by Dr. Elise L'Esperance at the Memorial Hospital in New York and by Dr. Augusta Webster at the Women's and Children's Hospital in Chicago. All of these projects have been conducted with the approval of their respective county medical societies. During the last eighteen months, with the active approval and coöperation of the Philadelphia County Medical Society, ten such clinics have been conducted in the medical schools and hospitals of that city. These clinics have been sponsored and financed by the Donner Foundation (the International Cancer Research Foundation).

The object of these clinics, whatever their name, has been the periodic physical examination of presumably well adults to screen out early cases of chronic disease with special emphasis on cancer. That they have met a definite public health need is evidenced by their published statistics and by the continued approval and support of the county medical societies with which they are associated. The public demand for this service is shown by the large attendance in these clinics and their long waiting lists. Each of these clinics has a filled appointment list six months or more in advance. The public demand is also evidenced by the fact that about 90 per cent of the examinees carry out the recommendations of the clinics and report to their family physician for treatment.

In the older clinics the incidence of malignant lesions discovered in the screening process is consistently about 1.5 per cent. Even more important is the higher percentage of unrecognized cardiovascular diseases and other types of pathology discovered in these examinations.

There are certain facts concerning each of these clinics and common to them that should be emphasized:

1. The clinic is conducted with the approval and active coöperation of the county medical society.
2. The clinic is conducted in an approved hospital or Class A medical school with easy access to all the clinical and laboratory facilities of the hospital.
3. The clinic is supervised by a physician who has had experience in the diagnosis and treatment of cancer.
4. The procedure consists of a history, complete physical examination, x-ray film of the chest, laboratory examination of blood, urine and serology, and the Papanicolaou vaginal smear in women.
5. The clinic invariably refers all cases with suspicious findings to the patient's private physician or lacking such, to a clinic or physician as directed by the county medical society.
6. The clinicians are paid for their services.
7. Each applicant is required to contribute five to ten dollars toward the expenses of the clinic if financially able.
8. The contributions do not cover the expense of the clinic and there must be additional subsidy for maintenance in at least the initial years.

The Cancer Commission believes that the California Medical Association should recognize the value of the work that has been done in these clinics for the periodic examination of adults and should adopt a definite policy toward the development of that work in California. There is wide public demand for this service. The American Cancer Society has accepted substantial contributions from the people of this State with the promise that among other things the money would be used to help maintain approved cancer clinics and "detection clinics." In carrying out that obligation the American Cancer Society looks to the California Medical Association and its component county societies to assure the high scientific standards of the clinic which it will subsidize with contributed public funds.

The House of Delegates of the American Medical Association on December 5, 1945, approved the report of the Council on Medical Service and Public Relations accepting the definition of Examination Clinics proposed by the American Cancer Society and also the stipulation that "no such clinics shall be established in any community without the approval of the county medical society." In so doing the A.M.A. has established a policy that that organization will approve clinics that are approved by the local component societies.

In order that there may be a uniform policy in California and to avoid the confusion and misunderstanding which have arisen elsewhere, the Cancer Commission believes that the standards and approval of "detection clinics" should be made at the state level by the C.M.A. Therefore, the Cancer Commission recommends that the C.M.A. adopt a "minimum standards" for the establishment and maintenance of "detection clinics." The Commission also recommends that the Council of the C.M.A. be authorized to approve such "detection clinics" as are recommended to it by the Cancer Commission as having fulfilled the "minimum standards." Enclosed is a suggested form for the "minimum standards" to guide in the formation of "detection clinics" in California and to form a basis for their approval.

In view of the widespread interest and publicity concerning cancer detection, the Commission recommends that the C.M.A. adopt a statement of policy defining its position in regard to periodic health examinations. The following statement is proposed:

The California Medical Association recognizes and asserts the importance of periodic physical examinations in all persons over forty years of age and in all women after pregnancy in order to detect early chronic diseases with special emphasis on the early detection of cancer.

Therefore, the C.M.A. strongly urges its members to adopt a regular program of complete periodic health examinations of all patients after middle life in their private practice. The C.M.A. also strongly urges the public to seek regular periodic complete physical examinations by their family physician.

Further, the C.M.A. approves the establishment of "detection clinics" by component county societies for the periodic examination of presumably well adults provided such clinics meet the "minimum standards" adopted by the C.M.A.

Respectfully submitted,
C.M.A. Cancer Commission.

* * *

CALIFORNIA MEDICAL ASSOCIATION MINIMUM STANDARDS FOR "DETECTION CLINICS"*

Purpose: The purpose of the "detection clinic" shall be to make periodic physical examinations of presumably well persons to discover early chronic disease with special emphasis on the early recognition of cancer or lesions that may lead to cancer.

Definition (of the American Cancer Society and Approved by the A.M.A.): "The cancer detection, cancer prevention or well-person clinic is designed to detect abnormalities not producing symptoms sufficient to send the patient to the doctor. These clinics do not diagnose or treat diseases."

Preamble: The "detection clinic" has proved to be a useful means of discovering early cancer or lesions that may lead to cancer. The clinic may be a valuable public health measure, but in order to protect the public both physically and mentally, it is essential that the examinations in these clinics be conducted with judgment and accuracy. The "detection clinic" properly conducted can be the means of saving the lives of cancer patients, but if not properly conducted, it can be a source of great danger. If the examinations in the clinic are not thoroughly and efficiently made early cancer may be overlooked and the patient dismissed with a sense of false security which will delay further adequate treatment. Also, failure of the clinic to evaluate suspicious lesions may develop an unjustified and ineradicable cancer phobia.

In order to assure the public of the best type of periodic examination and to protect the public from incomplete methods and unfounded fear, the C.M.A. has adopted the following program of "minimum standards" for "detection clinics" in California:

1. The "detection clinic" shall have the continued approval and support of the county medical society. The clinicians must be members of that society.

2. The clinic must be conducted in the out-patient department of a Class A medical school or an approved hospital. If located away from the institution it must be operated as an integral out-patient department of that institution.

3. Where there is no approved hospital or medical school in the community the "detection clinic" will be operated by the county medical society and all of the activities will be under the immediate supervision and control of the society. The clinic shall be conducted in a local hospital unless special approval is granted by the Cancer Commission after careful investigation.

4. The clinic shall be supervised by a physician who has had training and experience in the diagnosis and treatment of cancer.

5. The clinic shall have proper housing and adequate facilities and supplies to conduct complete physical examinations. The clinical laboratory and x-ray departments shall be easily accessible to it.

6. A sufficient number of clinicians shall be available to conduct the clinic at regular intervals and to provide for complete physical examination of every patient accepted by the clinic.

7. Adequate records shall be kept of the history, physical findings and recommendations and of the disposition of the patients. Sufficient personnel shall be available to provide for necessary nursing, stenographic and record services.

8. The examination shall include:
    1. History.
    2. Routine blood count, urinalysis and serology.
    3. X-ray film of the chest (mass survey).
    4. Nose and throat examination, including lips and interoral.
    5. Examination of the breasts.
    6. Physical examination of the chest, abdomen and extremities (including skin).
    7. Examination of lymph nodes: neck, axillae and groin.
    8. Pelvic examination.
    9. Rectal examination.
    10. Papanicolaou vaginal smear (where feasible).

9. Examinees that present suspicious history or abnormal physical findings shall be referred to their family physician for diagnosis and treatment. If there is no family physician, the patient shall be referred to a physician or clinic as directed by the policy of the county medical society.

10. A summary of the pertinent facts and recommendations of the clinic shall be sent to the physician or clinic to whom the patient is referred.

11. One month after such reference to physician the case shall be followed up by letter or social service visit and a complete report of the diagnosis and treatment shall be obtained.

12. Only presumably well adult patients will be accepted for examination. No patient under treatment for cancer will be accepted without permission of the attending physician.

13. Examinees shall be expected to make uniform contributions toward the expenses of the clinic if able to do so, but this shall not be in excess of the established cost of the examination.

14. All publicity concerning the clinic must have the approval of the county medical society.

15. Regularly scheduled periodic meetings will be held by the staff to study, review and follow up the cases seen in the clinic. An annual report of the work of the clinic will be sent to the Cancer Commission.

11. C.M.A. Advisory Planning Committee:

Chairman Hunton reported that the surveys of medical facilities approved by the Council in October, 1945, for a survey planned in Alameda County had proved impracticable. The committee recommended that these surveys be discontinued, that the findings of the Alameda County experiment be publicized, and that the county medical societies be urged to insure the provision of medical care of all people, regardless of their ability to pay fees. This recommendation was approved by the Council.

The committee also recommended that a committee from the Council be appointed to confer with officers of the State Board of Pharmacy relative to a ruling by the Surgeon General of the United States Public Health Service that ingredients of all prescriptions must be shown on the label. The Council approved the recommendation, and appointed a committee consisting of Edwin L. Bruck, Chairman; Dwight H. Murray, and Edward B. Dewey to look into this situation and bring back a report.

The committee discussed the Washington legislative situation and suggested that Messrs. Hunton and Hassard be authorized to go to Washington to confer with friends of medicine there. The Council granted this authorization, with an amendment that a physician be added. Councilor John Green was selected for this.

The committee recommended that the C.M.A. reiterate its position regarding the "California Plan" now proposed by several insurance companies.

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* Cancer Detection, Cancer Prevention or Well-Person Clinics, Health Maintenance and Cancer Prevention Clinics, and Examination Centers are all terms applied to such clinics.

It was agreed that the C.M.A. would reiterate its approval of the voluntary sickness insurance but express its disapproval of the establishment of fixed fee schedules by interests other than physicians themselves.

12. American Academy of Pediatrics:

Concerning a letter received from Doctor Crawford Bost, of date of May 3, 1946, it was voted to approve the study outlined by the C.M.A. and that the same be reported to the House of Delegates as an addendum to the Council report.

13. Visit to Mutual Broadcasting Studio:

Council Chairman announced that members of the Council were requested to go to the studio of the Mutual Broadcasting Company, after adjournment.

At the Studio, Mr. Clem Whitaker informed the Council concerning the featuring of an educational program proposed under the auspices of the C.M.A. in an effort to promote a better understanding by citizens of California concerning the advantages of voluntary health insurance plans over compulsory sickness insurance methods.

Two original sound recordings were presented, the first dealing with the founding of San Diego, and the second with an historical episode in the Marysville area.

It was stated that these programs, if approved by the Council, would be put on the radio once every Wednesday evening at the hour of 7:00 P.M. and would be presented under the name, "California Caravan."

14. Time and Place of Next Meeting:

Council on adjournment, agreed to meet at 7:30 A.M., on Tuesday, May 7, 1946, in Conference Room 6 of the Hotel Biltmore.

15. Adjournment:

Philip K. Gilman, *Chairman,*
George H. Kress, *Secretary.*

Minutes of the Three Hundred Thirty-second (332nd) Meeting of the Council of the California Medical Association

The meeting was called to order in Conference Room No. 7 at the Hotel Biltmore, Los Angeles, at 7:30 A.M., on Tuesday, May 7, 1946.

1. Roll Call:

Councilors Present: Philip K. Gilman, Chairman; Sam J. McClendon, E. Vincent Askey, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, Edwin L. Bruck, Sidney J. Shipman, E. Earl Moody, Edward B. Dewey, Walter S. Cherry, Dewey R. Powell, and George H. Kress, Secretary.

Present by Invitation: L. A. Alesen, Vice--Speaker; Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; E. T. Remmen, Chairman, Committee on Local Arrangements; John Hunton, Executive Secretary, Hartley F. Peart, Legal Counsel; Howard Hassard, Associate Legal Counsel.

2. Radio Programs:

The first item of business related to the programs reviewed the evening before at radio station KHJ. Discussion was had about the nature and scope of programs, their cost and other matters.

Mr. Whitaker stated that it was estimated that the cost of the program would be about $1,100 for each weekly broadcast.

It was stated by Mr. Whitaker that the plan could be tried out for three months, and if found unsatisfactory, he felt arrangements could be made whereby the contract could be abrogated.

Upon motion made and seconded, it was voted that the plan for these radio broadcasts be approved.

3. Address by Governor Earl Warren:

Council Chairman Gilman stated that Doctor J. B. Harris of Sacramento had telephoned that Governor Earl Warren would be happy to meet with the Council of the California Medical Association. It was agreed that Doctor Harris be informed that the Council would arrange time for such a meeting at 7:30 A.M., on Thursday, May 9th, in the conference breakfast room of the Hotel Biltmore.

4. Recess:

Upon motion made and seconded, it was voted to adjourn until 12:00 noon.

5. Meeting with Mr. Fred Howser:

After recess, the Council met in Room 6227 to meet informally with Mr. Fred Howser, District Attorney of Los Angeles County, who is a candidate for Attorney General of California.

A brief talk was made by Mr. Howser after which the Council took up other business.

6. Resolutions:

(a) A proposed resolution that might be introduced by a C.M.A. member at a meeting of the House of Delegates, the same relating to Doctor Morris Fishbein of the American Medical Association, received informal comment. No action was taken by the Council.

(b) A resolution concerning centralization of the medical profession's public relations work in Washington, D. C., was mentioned. Discussion was had concerning the desirability of bringing about a better grouping and centralization of public relations activities as carried on by the American Medical Association, the constituent state medical societies, and other affiliated groups. It was agreed that a resolution should be drafted in regard thereto, to be presented to the C.M.A. House of Delegates as an addendum to the report of the C.M.A. Council.

7. Report of the Committee on Editorial Policy:

A tentative report of the Committee on Editorial Policy was made, but no action taken other than to agree that an amendment to the C.M.A. Constitution should be presented to the House of Delegates, through which would be deleted the mandatory provision whereby the Association Secretary and Editor must be a person or persons holding the degree of Doctor of Medicine. It was agreed that such resolution should be presented to the House of Delegates.

8. Committee on Retirement Policy:

A preliminary report was made by Doctor Cline concerning retirement policies for employees of the California Medical Association.

Upon motion made and seconded, it was voted that the committee be continued with request to make further report later.

9. Adjournment:

Upon adjournment, it was voted the next meeting should convene at 7:30 A.M., on Wednesday, May 8, 1946.

Philip K. Gilman, *Chairman,*
George H. Kress, *Secretary.*

Minutes of the Three Hundred Thirty-third (333rd) Meeting of the Council of the California Medical Association

The meeting was called to order in Conference Room No. 6 at the Hotel Biltmore, Los Angeles, at 7:30 A.M., on Wednesday, May 8, 1946.

1. Roll Call:

Councilors Present: Philip K. Gilman, Chairman; Sam J. McClendon, E. Vincent Askey, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson,

R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, Edwin L. Bruck, Sidney J. Shipman, E. Earl Moody, Edward B. Dewey, Walter S. Cherry, Dewey R. Powell, and George H. Kress, Secretary.

Present by Invitation: L. A. Alesen, Vice-Speaker; Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; John Hunton, Executive Secretary, Hartley F. Peart, Legal Counsel; Howard Hassard, Associate Legal Counsel.

2. Dues for Year 1947:

The amount of dues of C.M.A. members, for year 1947, to be recommended to the House of Delegates was discussed. The income of the current year, a possible increase through return of military members, and decreases from other causes, were given consideration. After full discussion, on motion made and seconded, it was voted that the Council recommend to the House of Delegates that the State Association dues for 1947 be set at $100.00 per active member.

3. Place of 1947 Annual Session:

After discussion, it was agreed that this item should lie over for future consideration by the Council.

4. Budget for Next Fiscal Year:

Extensive discussion took place concerning the report and recommendations for a tentative budget submitted by the Executive Committee.

It was felt that it would be most desirable to have a proper explanation made in Executive Session of the House of Delegates, to permit delegates to take back to their respective component societies a better understanding of the activities that are under way, in plans to promote voluntary health insurance and related measures.

On motion made and seconded, it was voted that the budget should not be printed in the Official Journal. Also, that Doctors Cline, Gilman, and Mr. Hunton should confer upon the items to be further elucidated before the House of Delegates.

5. Report of Committee on Committees:

Chairman Gilman stated that the report of the Council's Committee on vacancies on Standing Committees and Editorial Board could be presented directly to the House of Delegates.

6. Recess:

Recess was had to hear informally, a candidate for the office of Attorney General, Mr. Carl Kegley of Los Angeles.

7. Budget:

After recess, the Council took up further consideration of the budget. Discussion was had concerning associate membership and conditions under which, through by-law provision, such membership is granted.

The items in the budget, submitted by Chairman Cline of the Auditing Committee, were then considered with special reference to certain public relations work.

8. Resolution from Santa Clara County Medical Society:

A resolution from the Santa Clara County Medical Society was presented. Copy of the resolution follows:

> Whereas, California Physicians' Service was organized primarily for the purpose of providing prepaid medical care among those of limited incomes; and
>
> Whereas, It was recognized that where it was possible to inaugurate this type of prepaid medical care in the various colleges in the State of California it was most desirable, for it was recognized that these students were the future leaders of the State; and
>
> Whereas, In certain colleges in the State of California concessions were made in order that this enrollment might be accomplished—so important was it considered from an educational point of view; and
>
> Whereas, One of the leaders in this program was Dr. Ray Lyman Wilbur, Chancellor of Stanford University and President of California Physicians' Service during the first five years of its existence; and
>
> Whereas, Stanford University is now considering entering into a contract for the medical care of its students and such contract is NOT with California Physicians' Service; and
>
> Whereas, Such an action can very easily be construed by the public as a failure of California Physicians' Service to cope with medical care problems (it being well known by the public that Dr. Wilbur was President of California Physicians' Service and Chancellor of Stanford University); now therefore, be it
>
> *Resolved,* That the Officers of California Physicians' Service and the Officers of the California Medical Association be asked to enter into a conference with the authorities of Stanford University to the end that every possible effort be made to bring the student medical care at Stanford University under California Physicians' Service.

Doctor Russell V. Lee, Director of the Palo Alto Clinic was present and explained the scope and other arrangements that had been made with Stanford University in relation to health coverage of students, through services at the Palo Alto Clinic and in out-patient clinics on the Stanford campus.

Comment was also made concerning ancillary services to be rendered by the Palo Alto Clinic, in connection with care of members of the athletic teams, educational health programs and sanitary inspections.

Doctor Lee stated that the services had been in operation since April 1, 1946, and that the services that had been rendered were presumably satisfactory to the students.

Doctors Lundquist, Bert L. Davis, and other representatives of the Santa Clara County Medical Society being present, also took part in the discussions. It was stated that students paid $10.00 per quarter for the medical care coverage received by them.

Reference was also made to conditions under which the Santa Clara County Medical Society had been contacted at the time the plan was first under consideration by President Tresidder of Stanford and representatives of the Palo Alto Clinic.

The question was raised on whether the contract between the Palo Alto Clinic and Stanford University authorities was in line with the stipulations laid down by the C.M.A. Special Committee on Prepayment Plans and California Physicians' Service, of which committee Dr. Loren R. Chandler was chairman.

After the departure of Doctor Lee and other representatives of the Santa Clara County Medical Society, the Council went into executive session to consider further the situation that had arisen at Stanford. Full discussion followed with reference to the implications that were involved in relation to procedures at Stanford and other educational institutions.

The point was made that because the House of Delegates would probably consider these same matters, it would be wise to have the entire subject lie over until the Friday morning meeting of the Council.

9. Senate Interim Committee to Study Compulsory and Voluntary Sickness Insurance Plans:

Before leaving, Doctor Russell V. Lee informed the Council that he had been appointed Chairman of an advisory committee to the Interim Committee of the California Senate, and that his advisory committee is making a study of voluntary and compulsory insurance plans existing in California and other states of the Union; and that he would be happy to receive suggestions in regard to the work.

10. Special Committee on Executive Secretaries for County Societies:

The special committee that had been appointed to report on the subject of executive secretaries for county medical units (Lloyd Kindall, Chairman; E. Vincent Askey, and Walter S. Cherry), submitted the following report:

On the morning of May 6th your Committee discussed the problems of Executive Secretaries with Messrs. Cochems, Waterson, Kihm, Donovan, Hunton, Read and Hassard, and Doctors Moore and Murray, and the thought behind all the discussions was that the preservation of the Practice of Medicine as we want it is at stake now.

The following facts were brought out:

(1) All doctors in the State must be informed of all legislation pertaining to the practice of medicine, whether local, state or federal.

(2) Good public relations must be maintained between the doctor and the patient.

(3) All doctors should take an active interest in placing proper men in public office, whether local, state, or federal.

(4) The C.M.A. should assume leadership in educating the doctors of this State.

Therefore, this committee recommends to the Council of the C.M.A. the following:

1. That we recognize the function of executive secretaries is two-fold: (1) Public Relations and Education, and (2) Local problems of each individual society.

2. That County Societies or groups of County Societies large enough to employ Executive Secretaries be encouraged to employ executive secretaries.

3. A Speakers Forum be established in as many counties as possible to educate both the doctor and the laity.

4. Indoctrination courses be encouraged in as many counties as possible for all members.

5. Secretaries of all County Societies meet at least once yearly.

6. Six or more field secretaries be employed and paid by the C.M.A., and placed under the Committee of Public Policy and Legislation, to inform and educate all doctors in counties not employing an executive secretary.

7. At the present time we are opposed to underwriting or subsidizing any county or counties in employing an executive secretary.

8. The need for executive secretaries in counties large enough to employ one should be determined by their own county and the problems involved should be worked out by their own council with the coöperation of the existing executive secretaries.

Discussion was had concerning field secretaries and other plans having relation thereto.

On motion made and seconded, it was voted to accept the report, with thanks and as conditions warrant, the Council attempt to put the plan into operation.

11. Time and Place of Organization Meeting:

It was agreed that the new Council would hold its organization meeting on Friday at 7:30 A.M., in the same room.

12. Adjournment:

On motion made and seconded, adjournment took place.

Philip K. Gilman, *Chairman*,
George H. Kress, *Secretary*.

Minutes of the Three Hundred Thirty-fourth (334th) Meeting of the Council of the California Medical Association

An executive session of the C.M.A. Council was called to order in Conference Room No. 6 at the Hotel Biltmore, Los Angeles, at 7:30 A.M., on Thursday, May 9, 1946.

1. Roll Call:

Councilors Present: Philip K. Gilman, Chairman; Sam J. McClendon, E. Vincent Askey, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, Edwin L. Bruck, Sidney J. Shipman, E. Earl Moody, Edward B. Dewey, Walter S. Cherry, Dewey R. Powell, and George H. Kress, Secretary.

Present by Invitation: Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; L. A. Alesen, Vice-Speaker, and Louis J. Regan, President, Los Angeles County Medical Association.

2. Conference with Governor Earl Warren:

As per arrangements made at the request of Dr. Junius B. Harris, of Sacramento, the Council convened at 7:30 A.M. to meet with the Governor of the State of California, Hon. Earl Warren, to informally discuss some public health matters of mutual interest. A full discussion of health insurance and the Governor's point of view on this subject took place. (Complete report of the proceedings is on file at the C.M.A. headquarters in San Francisco.)

After the departure of Governor Warren, a general discussion followed on various phases of C.P.S. and other sickness insurance plans.

Reference was also made to the approaching primary and run-off elections to be held in California this year.

3. Adjournment:

There being no further business, the meeting was adjourned.

Philip K. Gilman, *Chairman*,
George H. Kress, *Secretary*.

Minutes of the Three Hundred Thirty-fifth (335th) Meeting of the Council of the California Medical Association

The meeting was called to order in Conference Room No. 6 at the Hotel Biltmore, Los Angeles, at 7:30 A.M., on Friday, May 10, 1946.

1. Roll Call:

Councilors Present: Sam J. McClendon, John W. Cline, E. Vincent Askey, L. A. Alesen, H. Gordon MacLean, Sidney J. Shipman, E. Earl Moody, Louis J. Regan, Walter S. Cherry, C. V. Thompson, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, Edwin L. Bruck, Lloyd E. Kindall, Frank A. MacDonald, John W. Green.

Present by Invitation: Dwight H. Murray, Chairman Committee on Public Policy and Legislation; John Hunton, Executive Secretary; Howard Hassard, Legal Counsel; and Rollen Waterson, Executive Secretary, Alameda County Medical Association.

2. Election and Appointment of Officers:

On motion made and seconded, Lloyd E. Kindall was named Secretary Pro Tem.

On motion duly made and seconded, Councilor Edwin L. Bruck was elected Chairman of the Council.

On motion duly made and seconded, Councilor Sidney J. Shipman was elected Vice-Chairman of the Council.

President McClendon named Councilors Sidney J. Shipman (Chairman), Lloyd E. Kindall, and H. Gordon MacLean as members of the Auditing Committee for 1946-47. These nominations were approved by the Council.

By unanimous consent, the firm of Peart, Baraty and Hassard was appointed Legal Counsel for the coming year.

By unanimous consent, John Hunton was appointed Executive Secretary for the coming year.

The salaries of the Legal Counsel and Executive Secretary were approved at the previous levels.

By unanimous consent, Doctor L. Henry Garland was appointed Secretary and Doctor Dwight L. Wilbur was appointed Editor of the Official Journal, honorariums of these officers to be determined by the Executive Committee.

It was agreed that the distribution of text pages in the Official Journal would be left in the hands of the Editor.

3. House of Delegates Reference Committees:

Doctor Dell T. Lundquist of Santa Clara County appeared by invitation and suggested that Reference Committees of the House of Delegates be appointed in advance and that resolutions and other business to be presented to these committees be discussed prior to meetings of the House of Delegates and Reference Committee reports on such matters be presented in advance.

It was pointed out that members of the House of Delegates are not known many months in advance of the Annual Session and that the way must be left open for the introduction of new business at the time of the Annual Meeting. The Council took this request under advisement.

4. Dues for 1947:

On motion duly made and seconded, it was voted that the Executive Secretary prepare a digest of the reasons for the amount of 1947 dues, and forward copies to all delegates, alternates, presidents and secretaries of county medical societies and members of the Council.

5. Councilor Visits:

Doctor Murray pointed out the value of regular Councilor visits to the county societies and urged that the Councilors and Officers make a special effort to reëstablish such regular visits for the purpose of keeping the membership at large advised of all current activities.

6. Advisory Committee to the Woman's Auxiliary to the C.M.A.:

President McClendon appointed Doctors John V. Barrow of Los Angeles and A. B. Diepenbrock of San Francisco to serve along with the Association President, President-elect and Secretary as members of the Advisory Committee to the Woman's Auxiliary. These appointments were confirmed by the Council.

7. Assistant to the Executive Secretary:

On motion duly made and seconded, the Executive Secretary was instructed to seek an assistant and to take preliminary steps to secure such assistant, the appointment to be subject to approval by the Council.

8. Field Secretaries:

On motion duly made and seconded, it was voted that field secretaries to be employed by the Association would be under the direct control of the Executive Secretary, with advice and instructions on the activities of such field secretaries to come from the Committee on Public Policy and Legislation.

9. Industrial Accident Commission Fee Schedule:

The Executive Secretary was authorized to work for higher fees for office and hospital visits for compensation cases. Acceptance of any fee schedule is to be made as not prejudicing the right of the Association to make further requests for establishment of fair fees by the Industrial Accident Commission.

10. California Plan:

On motion by Moody, amended by Cline, it was voted that a letter be sent to all members outlining the action of the House of Delegates on the "California Plan" of certain insurance companies. This letter would specify the disapproval of the House of Delegates of the type of plan proposed by these companies.

11. Stanford University Health Service:

On motion duly made and seconded, it was voted that Doctor Russell Lee of the Palo Alto Clinic be requested by the Council to furnish the Association with a copy of the contract between the Palo Alto Clinic and Stanford University for the provision of a health service for Stanford students. If Doctor Lee does not furnish such a contract, a similar request is to be made of Stanford University. If neither request produces a copy of this contract, the subject of this service shall be considered at the next Council meeting.

12. Public Relations Campaign:

Doctor Alesen moved that the Association contribute to the radio program of a news commentator, and moved that the Public Relations Counsel be instructed to contribute toward this work.

Doctor Cline offered an amendment that this matter be placed in the hands of the Committee on Public Policy and Legislation. On adoption of the amendment, the original motion as amended was adopted. It was also voted that the attention of the National Physicians' Committee be drawn to the policies of nationally broadcasting news commentator programs handled by commentators sympathetic toward the free enterprise system.

13. Instructions to C.M.A. Representatives in Washington:

After discussion it was voted to instruct Doctor Green and Messrs. Hunton and Hassard to take the following steps in their coming visit to Washington, D. C.:

(a) The A.M.A. to be notified, preferably by telephone call from President McClendon to the General Manager or Legal Counsel of the A.M.A. of this trip, a conference with A.M.A. representatives to be requested.

(b) Part II of the proposed Taft Bill should be deleted if possible.

(c) C.M.A. representatives to use their best judgment in meeting the Washington situation without committing the C.M.A. to specific action or endorsement of suggested sickness insurance programs.

14. Next Meeting of the Council:

The time and place of the next meeting are to be set by the Chairman in consideration of the convenience of Senator Sheridan Downey and Col. Paul Holbrook of Arizona, who wish to confer with the Council on national legislative matters.

15. Adjournment:

There being no further business, the meeting was adjourned.

Edwin L. Bruck, *Chairman*,
Lloyd E. Kindall, *Secretary Pro Tem.*

MEMBERS' ANNUAL MEETING OF TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Twentieth (20th) Meeting of Members

Pursuant to call of the president and notice by the secretary duly and regularly given and delivered to each member in accordance with the by-laws, the regular annual meeting of the members of the *Trustees of the California Medical Association*, a California corporation, was held in Conference Room No. 6 of the Hotel Biltmore, Los Angeles, California, on Friday, May 10, 1946, at the hour of 9:00 A.M., following the annual organization meeting of the Council of the California Medical Association.

There were present: Sam J. McClendon, John W. Cline, E. Vincent Askey, L. A. Alesen, Edwin L. Bruck, Sidney J. Shipman, E. Earl Moody, Louis J. Regan, Walter S. Cherry, Herbert A. Johnston, Jay J. Crane, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, H. Gordon MacLean, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and C. V. Thompson.

Absent: L. Henry Garland.

A quorum present and acting.

Sam J. McClendon, president of the corporation, acted as chairman of the meeting. Lloyd E. Kindall, acted as secretary pro tem of the meeting.

The minutes of the last meeting of the Members of the *Trustees of the California Medical Association* having been sent to all members, upon motion duly made and seconded, it was voted that the same be approved and the actions therein taken ratified.

The meeting then proceeded to the election of directors of the corporation to serve for the ensuing year or until their successors shall be elected and qualified. Upon motion duly made, seconded and unanimously carried, the following were elected to serve as directors of the corporation for the ensuing year or until their successors shall be elected and qualified:

Sam J. McClendon, John W. Cline, E. Vincent Askey, Edwin L. Bruck, Sidney J. Shipman, Lloyd E. Kindall, L. Henry Garland.

After discussion, and upon motion duly made, seconded, and unanimously carried, it was,

Resolved, That Section 1 of Chapter XII of the by-laws of this corporation is hereby amended to read as follows:

"Section 1. The board of directors shall from time to time designate one or more banks in San Francisco or elsewhere in the State of California, to act as depository or depositories of this corporation, with which the funds of this corporation and its securities shall be deposited. All securities of this corporation shall immediately upon receipt thereof by the corporation or any director or officer thereof be forthwith deposited by the secretary or the treasurer with a depository of this corporation for safekeeping, and after such deposit such securities shall be withdrawn only upon and by resolution of the board of directors."

And be it further,

Resolved, That the secretary of this corporation is hereby instructed to insert in the book of by-laws of this corporation a certificate showing the foregoing amendment of Section 1, Chapter XII of the by-laws.

The president announced that the foregoing resolution was adopted by an affirmative vote of more than two-thirds of all members of the corporation.

After further discussion, and upon motion duly made, seconded and unanimously carried, it was

Resolved, That all checks, drafts, and other instruments obligating this corporation, *Trustees of the California Medical Association*, to pay money shall be signed by at least two of the following persons:

Sam J. McClendon, President; L. Henry Garland, Secretary; Edwin L. Bruck, Assistant Secretary; Sidney J. Shipman, Treasurer; Lloyd E. Kindall, Assistant Treasurer; John Hunton, Executive Secretary.

And be it further,

Resolved, That the secretary of this corporation shall forward a duly certified copy of this resolution to each bank in which this corporation maintains an account. And be it further,

Resolved, That each bank to which a certified copy of this resolution is delivered shall conclusively deem this resolution in full force and effect until it receives notification to the contrary from this corporation.

There being no further business to come before the meeting, upon motion duly made, seconded, and unanimously carried, the meeting adjourned.

Sam J. McClendon, *President*,
Lloyd E. Kindall, *Secretary Pro Tem.*

DIRECTORS' REGULAR MEETING OF TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Forty-second (42nd) Meeting of the Board of Directors

Pursuant to the by-laws, a regular meeting of the Directors of the *Trustees of the California Medical Association* was held in Conference Room No. 6 of the Hotel Biltmore in Los Angeles, California, on Friday, May 10, 1946, at the hour of 9:30 A.M.

Present were the following directors: Sam J. McClendon, John W. Cline, E. Vincent Askey, Edwin L. Bruck, Sidney J. Shipman, Lloyd E. Kindall.

Absent: L. Henry Garland.

Temporary Chairman, Sam J. McClendon, called the meeting to order and Lloyd E. Kindall acted as Secretary Pro Tem.

The Temporary Chairman stated that the first order of business was the election of officers to hold office for one year and until their successors were elected or appointed.

On nominations duly made and seconded and ballots duly cast and taken, the following Directors were unanimously elected to the offices of the corporation set opposite the name of each thereon respectively:

Sam J. McClendon, President; John W. Cline, First Vice-President; E. Vincent Askey, Second Vice-President; L. Henry Garland, Secretary; Edwin L. Bruck, Assistant Secretary; Sidney J. Shipman, Treasurer; Lloyd E. Kindall, Assistant Treasurer.

There being no further business, upon motion duly made and seconded, it was voted to adjourn.

Sam J. McClendon, *Temporary Chairman and President*,
Lloyd E. Kindall, *Secretary Pro Tem.*

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (19)

Butte-Glenn County (1)

Hoiland, Dean, *Paradise*

Contra Costa County (2)

Husser, George D., *Richmond*
Zinnaman, Burton L., *Richmond*

Fresno County (1)

Hashiba, G. K., *Fresno*

Riverside County (1)

Batzle, Joseph H., *Riverside*

Sacramento County (3)

Ito, Masayashi, *Sacramento*
Holstein, Theodore, *Sacramento*
O'Grady, George E., *Jackson*

San Bernardino County (1)

Dempsey, Thomas F., *San Bernardino*

San Diego County (2)

Clark, Adrian E., *La Mesa*
Ostendorph, John E., *National City*

San Francisco County (3)

Marcus, Sanford Albert, *San Francisco*
Saunders, Cecil Allen, *San Francisco*
South, Reagan H. F., *San Francisco*

San Mateo County (2)

Benner, Alan Norton, *San Mateo*
Boone, Thomas H., *Belmont*

Santa Barbara County (1)

Martin, Walter H., *Santa Barbara*

Santa Clara County (1)

Cox, John E., *Los Gatos*

Solano County (1)

Quinn, E. M., *Vallejo*

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† For roster of officers of component county medical societies, see page 4 in front advertising section.

Transfers (8)

Andrews, A. V., from *Merced County to Orange County*
Bernstein, Theodore I., from *Los Angeles County* to *Santa Barbara County*
Dufficy, Rafael, from *San Francisco County* to *Marin County*
Galbraith, Harold F., from *Ventura County* to *Orange County*
Green, Berryman, from *Riverside County* to *Orange County*
Johnson, C. A., Jr., from *San Joaquin County* to *Napa County*
Marchus, Donald B., from *Shasta County* to *Napa County*
Marnell, Frank S., from *San Joaquin County* to *Santa Cruz County*

Resignations (9)

Baba, George R., *San Francisco County*
Bischoff, Harold W., *San Francisco County*
Chase, J. S., *San Francisco County*
Crismon, Kenneth A., *Los Angeles County*
Davenport, J. Dryden, *Los Angeles County*
Fogerty, Clement A., *San Francisco County*
Kimball, Nellie T., *Los Angeles County*
Wells, Carl H., *Los Angeles County*
Wells, Lelia H., *Los Angeles County*

Retired Members (33)

Avery, John Waite, *Los Angeles County*
Bakewell, Benjamin, *Santa Barbara County*
Burke, Edward W., *San Bernardino County*
Eklund, Oscar E., *San Francisco County*
Fearn, J. Radford, *Alameda County*
Filipello, Eugene, *Santa Clara County*
Friedman, Maurice, *Los Angeles County*
Gagnon, A. L., *San Diego County*
Girard, Frank R., *San Francisco County*
Hill, Robert B., *Los Angeles County*
Jones, Ellis W., *Los Angeles County*
Kidder, Frank W., *Los Angeles County*
King, Ernest Harold, *Los Angeles County*
Magan, Percy T., *Los Angeles County*
Moore, Leroy Scott, *Santa Clara County*
Myers, Thomas Chalmers, *Los Angeles County*
Patrick, Marcia A., *Los Angeles County*
Powers, Allan Raymond, *San Joaquin County*
Rees, Harry C., *Los Angeles County*
Rose, Louis M., *Santa Clara County*
Rosencrantz, Esther, *San Francisco County*
Ryder, B. E., *Los Angeles County*
Sample, Thomas Nelson, *Fresno County*
Savage, William W., *San Bernardino County*
Sharp, James G., *San Francisco County*
Simms, John S., *Los Angeles County*
Smith, Ben H., *Los Angeles County*
Staniford, Kenneth J., *Fresno County*
Taylor, Ross O., *San Diego County*
Thomason, George, *Los Angeles County*
Welpton, Martha, *San Diego County*
Wood, C. H., *Los Angeles County*
Zook, A. J., *Los Angeles County*

Associate Members (11)

Brown, Ellen, *Alameda County*
Coleman, E. H., *Fresno County*
Condit, J. C., *Alameda County*
Custer, W. C., *Alameda County*
Erickson, Elenore, *Alameda County*
Farnsworth, S. F., *Alameda County*
McLean, Lester, *Solano County*
Mills, Martin, *Contra Costa County*
Singer-Brooks, Charlotte, *Santa Barbara County*
Stannard, Amy, *Alameda County*
Vedder, Edward B., *Alameda County*

In Memoriam

Alden, Eliot. Died at Los Angeles, April 10, 1946, age 71. Graduate of Harvard Medical School, Boston, Massachusetts, 1901. Licensed in California in 1906. Doctor Alden was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Hoffman, Laurence Harold. Died at San Francisco, April 23, 1946, age 68. Graduate of Cooper Medical College, San Francisco, 1897. Licensed in California in 1898. Doctor Hoffman was a retired member of the San Francisco County Medical Society, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

◆

Kasanin, Jacob Sergi. Died at San Francisco, May 4, 1946, age 48. Graduate of the University of Michigan Medical School, Ann Arbor, 1921. Licensed in California in 1939. Doctor Kasanin was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Percy, James Fulton. Died at Los Angeles, April 26, 1946, age 82. Graduate of the Bellevue Hospital Medical College of New York, 1886. Licensed in California in 1910. Doctor Percy was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Ransom, Dow Harvey. Died at Madera, April 7, 1946, age 65. Graduate of the Cooper Medical College, San Francisco, 1907. Licensed in California in 1907. Doctor Ransom was a Retired Member of the Fresno County Medical Society, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

◆

Reilly, William. Died at San Francisco, April 27, 1946, age 53. Graduate of the College of Physicians and Surgeons of San Francisco, 1918. Licensed in California in 1918. Doctor Reilly was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Reynolds, Julius Milton. Died at Long Beach, April 16, 1946, age 52. Graduate of the Atlanta School of Medicine, Georgia, 1913. Licensed in California in 1933. Doctor Reynolds was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Swearingen, Forrest Custer. Died at Pomona, March 24, 1946, age 60. Graduate of Rush Medical College, Illinois, 1914. Licensed in California in 1915. Doctor Swearingen was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

General Bradley Views Health Insurance

General Omar N. Bradley, veterans' administrator, told the Senate labor committee today that any compulsory health insurance legislation should protect veterans' existing rights to free medical care and hospitalization.

Bradley noted that the Wagner-Murray-Dingell bill on which hearings are being held does not specify means of finance. But he said that the term "prepaid personal health service benefits" indicates contributions are anticipated from employed persons. "This," he said, "would require the employed veteran to contribute toward a benefit to which he is already entitled without charge under existing law, in that he is entitled without cost to himself to hospital or out-patient treament of service-connected disability and to hospital treatment of non-service connected disability when a bed is available.

Expressing no opinion as to the advisability of the legislation, General Bradley said he had studied it purely from the veteran's standpoint and added that he is convinced the veterans' hospitalization benefits should remain exclusively under his administration.—The Sacramento *Bee*, May 3.

Lessons from Military Psychiatry

Even though the public is pessimistic about the recovery rate of mental illness, 60 per cent of Army mental combat casualties were salvaged for duty within 15 miles of the front, Brigadier General William C. Menninger, director, Neuropsychiatry Division, Office of the Surgeon General, reported recently in New York.

He discussed the topic, "Lessons from Military Psychiatry for Civilian Psychiatry," in the second Menas S. Gregory lectureship of the New York University College of Medicine, on April 27.

Clinical knowledge developed by the Army showed "undoubtedly that psychiatry is only on the doorstep of its potential usefulness," General Menninger declared. He based his statement on that fact that a million American soldiers were admitted to Army hospitals for treatment of mental disorders and personal maladjustments during his past five years in military service.

"Only 7 per cent of those cases were of a really serious nature," he said. "Between 75 and 80 per cent were psychoneurotics, while the rest suffered from personality disorders."

"It is an accepted fact that in the ideal civilian practice clinical psychologists and psychiatric social workers should be utilized," he said. "But there are many large civilian clinics and hospitals that do not use them. The Army applied this plan and convinced those of us in charge of their essentiality."

General Menninger urged that a public education campaign similar to those for cancer and tuberculosis be undertaken for psychiatry. "Psychiatry must overcome its self-destructive trends by actively participating in and becoming an intricate part of the daily practice of all medicine," he stated.

Need for Cancer Information Is Stressed

The percentage of cure cases in cancer would be raised from 15 to 40 per cent if more people understood the disease, Dr. Leo H. Garland told the San Francisco Division of the American Cancer Society recently.

Speaking at a luncheon, Dr. Garland, San Francisco x-ray man, emphasized the four elementary cancer facts:

"Cancer is uncontrolled growth of body cells.

"Cancer can be cured in early stages.

"Many cancer cases are being cured now.

"Cancer is not contagious as far as we know, nor is it hereditary in itself."

Tagging cancer as "the second most important killer of persons," he stated the disease killed twice as many persons during the war as did the Japanese.

His speech was part of the educational campaign now being fostered by the Cancer Society. It was delivered at a luncheon at the Palace Hotel.

Mrs. Joseph L. Gould, San Francisco Commander, presided at the luncheon. Dr. Harold Brunn made the opening address.

Along with its educational program, the American Cancer Society is in the midst of a campaign for funds. —San Francisco *Chronicle*, March 30.

Photograph of Service Medical Men. Taken at Testimonial Dinner to Service Men of University of California Medical School, Palace Hotel, San Francisco, April 25, 1946. (See May CALIFORNIA AND WESTERN MEDICINE, page 317.)

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Public Health Training Fellowship

A grant for the establishment of 125 fellowships to train physicians and sanitary engineers in public health has been approved by the National Foundation for Infantile Paralysis.

Each fellowship provides a year's graduate training in a school of public health or a school of sanitary engineering. The fellowships, available either during the academic year beginning in the fall of 1946 or the fall of 1947, are open to men and women citizens of the United States under 45 years of age.

Purpose is to aid in recruitment of trained health officers, directors of special medical services, and public health engineers to help fill some of the 900 vacancies in public health medical positions and 300 vacancies for public health engineers, existing in state and local health departments over the country. The fellowships are reserved for newcomers to the public health field. They are not open to employees in state and local health departments, for whom federal grants-in-aid are already available to the states.

Applicants for fellowships may get details by writing the Surgeon General, U. S. Public Health Service, Attention: Public Health Training, 19th and Constitution Avenue N.W., Washington 25, D. C. Applications for training in the fall term of 1946 should be filed promptly.

Parent-Teachers Health Education Drive

Every effort will be made to carry out a resolution calling for "positive programs of health education" which was adopted at the California Congress of Parents and Teachers held in San Francisco last May.

This was the promise of Mrs. Rollin Brown of Los Angeles, newly elected president of the congress, who observed that "it is a sad fact that only 29 counties in California have full-time health services."

Mrs. Brown urged that all counties should have public health services and that parents should be educated to the purposes of the treatments. "It will not help unless parents go along with their children on health services," she said, adding that she would like to see an extension of immunization programs.

Help Asked in Encephalitis Study

Coöperation of practicing physicians in a special investigation of encephalitis is asked by the California State Department of Public Health which is conducting the study.

The investigation will include epidemiological follow-up of suspected human and animal cases, laboratory diagnosis, and investigation of mosquito vectors.

The request for coöperation points out that accurate diagnosis depends upon securing:

a. Blood specimens (20 c.c.) as soon as the disease is suspected and second specimens during convalescence, for comparison of antibody titre;

b. Autopsy material for virus isolation.

Physicians are asked to:

1. Secure blood specimens as soon as encephalitis is suspected and send to the State Bacteriological Laboratory, Life Sciences Building, University Campus, Berkeley, 4. (The second specimen should be taken 14-21 days after date of onset.)
2. Report suspected cases at once by telephone to local health officer.
3. Notify the State Department of Public Health by telephone immediately in event of a death due to encephalitis. It is essential that any specimens for virus work be collected before embalming.

Stomach Ulcer Treatment

Dr. Benjamin M. Bernstein of New York University, described use of a stomach ulcer treatment which he said was "in complete contradiction" with a theory that gastric acidity irritates ulcers.

In a report to the American College of Physicians' twenty-seventh meeting, he said he and fellow investigators had employed in 75 ulcer cases an injected histamine. He declared it actually stimulates acid in the stomach, but at the same time has the faculty of opening up constricted vessels in the body.

Dr. Bernstein said complete relief of ulcer pain was achieved in 69 cases in from four to 18 days on daily injections.

He added that from a special study of 18 patients designed to prevent recurrence of symptoms "we can report that almost all of these patients, who previously had two or more episodes per year, have now for the first time in years gone through the spring season free from ulcer pain."

Tuberculosis Chemo-therapy

Subtilin and eumycin, new extracts taken from the air, have proven of initial value in experiments directed against tuberculosis, the American Society of Bacteriologists was informed.

Dr. A. J. Salle of the University of California told the forty-sixth general meeting of the society that "results so far lead us to believe that subtilin may prove to be a valuable agent or drug in the chemo-therapy of tuberculosis."

His report followed by a few minutes one in which Drs. Edwin A. Johnson and Kenneth L. Burdon of Baylor University told the nearly 1,000 delegates that eumycin "prevents entirely or definitely inhibits" the growth of certain human types of tuberculosis.

The results of the unrelated experiments were announced less than twenty-four hours after the society received reports indicating that another agent, the drug streptomycin, has proven disappointing in relation to tuberculosis.

Study of Child Health Services*

All practicing physicians and dentists will be asked in the near future to fill out simple questionnaires giving data necessary to a study being undertaken by the American Academy of Pediatrics in coöperation with government and lay organizations to determine the extent and availability of existing child health facilities in each community.

Asking coöperation in filling out and returning the questionnaires accurately and promptly, the Academy points out that "this is a study by and for the medical profession and, as such, its importance cannot be overemphasized, especially in these times of proposed and impending legislation."

The present study is an outgrowth of a plan for the study of child health services throughout the United States which was sponsored in the fall of 1944 by the American Pediatrics Society and which now has been adopted by the Academy. Expenses for the most part are being covered by funds furnished by voluntary health groups and agencies.

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* See reference in Minutes of the C.M.A. House of Delegates in this issue of CALIFORNIA AND WESTERN MEDICINE on pages 360 and 388.

Basically the study falls into four main fields of inquiry:

1. *Hospital Facilities.* Detailed information concerning pediatric care will be sought from all hospitals. The greatest part of this information will be collected by the Commission of Hospital care which is conducting a study through the State at the present time. The remainder will be collected by pediatricians making personal visits to hospitals assigned to them in their localities.

2. *Community Health Services,* both official and voluntary. An appraisal of the extent and quality of services such as well-baby conferences, school health programs and public health nursing will be made.

3. *Distribution, Qualifications, and Activities of Professional Personnel* in relation to the amount of time spent by all in the care of infants and children. Further detailed information will be gathered from the pediatricians.

4. *Pediatric Training* as given by the various medical schools is to be studied at a later date by a separate committee on medical education.

The study is to be carried out at a State level with each Academy of Pediatrics State chairman being responsible for the work in his area. Full time executive directors, who are also Academy members in California, have been appointed, and they will be responsible for the administration of the program.

Smallpox in San Francisco First Outbreak Since 1939

The first case of smallpox to be reported from San Francisco since 1939 occurred in a member of the armed forces who was flown from Japan and developed symptoms en route. On December 29th, 1945, the day of his arrival, he was hospitalized with a rash which subsequently was diagnosed as smallpox. He has a history of an unsuccessful vaccination in 1943. From that time until March 13th, five additional cases have occurred among San Francisco residents although only coincidental relationship has been established with the initial case.

The second case, onset January 15th, occurred in a woman who lived in the neighborhood of the military hospital but is not known to have had any contact with the case. Formerly a school teacher, she had been vaccinated many times when school immunizations were done but has no scar and no history of a nonimmune reaction.

The other four cases were in members of two Negro families living in the same house in another section of the city. There has not been established any epidemiological relationship between these cases and either of the first two.

The first case of this group of four was in a four-year-old unvaccinated boy whose onset was February 12th but who did not receive medical attention for a week. Although household contacts were immediately vaccinated, cases developed in three persons, all of whom had histories of previous immunization: his mother, onset February 28th; a seven-year-old boy and his mother, onsets March 5th.

Aside from the sudden appearance of six cases of smallpox in a city which had been free of the disease since 1939, there are several points of particular interest in the outbreak.

Five of the six cases had been previously vaccinated. On the record of one of the five, the vaccination was recorded as "unsuccessful" and another had a history of never having had a primary reaction despite repeated vaccinations. Three persons had scars as evidence of previous immunization and although dates could not be established, vaccination had been within the past seven years in the case of the seven-year-old boy.

Three cases possibly could have been prevented had immediate medical attention been secured for the four-year-old boy, since less time would have elapsed between exposure and vaccination of contacts.

It would seem that the strain of virus responsible for the San Francisco outbreak is a virulent one. One case, in the unvaccinated boy who went without medical attention for a week, has been unusually severe.*

* * *

CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH
(Bulletin of April 12, 1946.)

To All Health Officers:

In California to date, 12 cases of smallpox have been reported, as follows:

1. Alameda County	2
(Origin outside the United States)	
2. San Diego County	1
Origin within City of San Diego)	
3. San Francisco	9
(Origin within city 6)	
(Origin outside the United States 3)	
Total	12 No deaths

In the State of Washington, 40 cases with 7 deaths had been reported up to April 11th.

* * *

San Francisco's Blood Bank's Future Needs Cited

In March, 1946, the Irwin Memorial Blood Bank of the San Francisco County Medical Society passed the 65,000 mark in donors. In its four and one-half years of existence, more than 65,653 donors have given their blood and during the same period some 40,000 bloods have been distributed for transfusions. In 1945, donors gained 1,500 over the preceding year. Bloods distributed were 1,300 above the 1944 figure.

The bank made rapid strides under the stress of war emergency when the need for blood was apparent to all. At times, however, operations were on a very narrow margin and often the refrigerators were nearly empty.

In order to keep the cost of transfusions at the lowest possible level to residents in this community, the commission decided to try again this year to operate on a basis of one donor for one unit of blood. This decision, however, has imposed a great responsibility on the commission and the staff. . . .

The only reason the one donor for one unit of blood can be considered is the hope that with more publicity, as well as the coöperation of doctors and the public, the bank may receive some 6,000 voluntary donations this year. This figure is not excessive if present demand is to be met. These donations must be exclusive of hospital replacements, which means 6,000 a year, or 500 per month. In other words, the bank must have some 20 voluntary donations a day. . . . —*Bulletin* of the San Francisco County Medical Society, April, 1946.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Medical Education Standards

In an editorial entitled "Financial Support of Medical Schools," *The Journal of the American Medical Association* anticipates a serious lowering of standards in medical education.

"The war dealt a serious blow to the quality of medical education," *The Journal* says in its April 27 issue, adding: "The failure of the Selective Service System to provide for the training of scientists has already resulted in a serious deficiency of instructors, particularly in preclinical subjects. The rosters of candidates for Doctor of Philosophy degrees in our larger universities have been largely nonexistent for some four or five years.

"A further threat to the quality of medical education lies in financial developments involving the budgets of our medical schools. Dr. Frank E. E. Germann pointed out in a recent issue of *Science* that the current salaries in effect for instructors in science are such as to make it virtually impossible to attract qualified men and women to these institutions as teachers. He says, 'A small number of our highly endowed educational institutions have been able to hold and attract outstanding scholars because of their higher salary scales, but the average private or state-supported institution has been forced into mediocrity.' He asks, 'What future can we promise young men and women holding pre or postdoctoral fellowships at $1,800 to $3,000 when we still offer $2,000 for assistant professors and require that they have the doctorate degree? What chance do we have to secure a competent teacher in science when a full professor, after thirty years of service, may never reach a salary of $4,000?' "

Herms Commended by Army, Navy

Commendation has been received at the University of California from both the Army and the Navy, for the work performed by Dr. W. B. Herms, professor of parasitology on the Berkeley campus and lecturer in tropical medicine in the Medical School. With rank of lieutenant colonel, Professor Herms aided in the sanitation problems of expeditionary forces, particularly in the Pacific islands.

U. C. Man Elected to Harvard Post

Dr. John H. Lawrence, assistant professor of medical physics on the Berkeley campus of the University of California, has been elected president of the Harvard Medical Alumni Association.

Dr. Lawrence, who directs the medical research of the University's Radiation Laboratory, will preside at a meeting of the Association July 3 on the occasion of the annual scientific gathering of the American Medical Association in San Francisco, Dr. Roger Lee, president of the A.M.A. will be the speaker for the alumni meeting.

Net Gain of 1,892 Physicians

There were 5,707 additions to the medical profession in 1945, according to data presented in the forty-fourth annual compilation of medical licensure and allied statistics by the Council on Medical Education and Hospitals of the American Medical Association and published in the May 11 issue of *The Journal of the American Medical Association.*

"The number of physicians removed by death in the United States and possessions in the same period was 3,815," *The Journal* says, adding: "It would appear therefore that the physician population in the United States last year increased by 1,892."

During 1945 there were 9,153 licenses to practice medicine and surgery issued by the medical examining boards of the 48 states, the District of Columbia, Alaska, Hawaii, Puerto Rico and the Virgin Islands. Of these licenses, 5,541 were issued after examination and 3,612 by reciprocity and endorsement of other state licenses or of the certificate of the National Board of Medical Examiners.

California, with 1,208, issued the greatest number of licenses during 1945. New York issued 799 and Pennsylvania 518.

Increases in the number of physicians registered last year as compared with data reported for 1944 were noticeable in a number of states and particularly in Arkansas, California, the District of Columbia, Florida, Illinois, Indiana, Iowa, New Jersey and the possessions, while more pronounced decreases in registration occurred in Georgia, Kansas, Kentucky, Maryland, Michigan, Mississippi, Missouri, Nebraska, Ohio, Pennsylvania and Virginia.

The greatest number of graduates of any one school examined was 228, representing Indiana University School of Medicine. Of this number, 213 were examined in Indiana and 15 in seven other states. Graduates of the University of Pennsylvania were examined in the greatest number of states—22.

Twenty-seven approved medical schools in the United States had no failures before medical licensing boards.

Altogether there were 5,929 candidates who appeared before medical examining boards in 1945, of whom 5,341 passsd and 588, or 9.9 per cent, failed. The greatest percentage of failures represented two groups—foreign and unapproved schools.

Council Secretary Victor Johnson reported that the wartime accelerated medical program started about July 1, 1942, and the peak of graduates was reached in 1944, when two classes were graduated at most schools. The total number of graduates for the four session three year cycle to July 1, 1945 was 20,662. For the four years 1942 to 1945 inclusive 35,803 physicians received licenses. This figure includes physicians previously licensed who are migrating to other states and veteran medical officers not returning to their original state of practice.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Medicine Takes the Initiative

The American Medical Association has announced development of a country-wide system of voluntary sickness insurance protection to be operated on a non-profit basis by local medical groups. The average cost to any individual policyholder enrolled under the coördinated voluntary system will be "considerably less" than the $144 annual payroll deduction suggested under the President's compulsory health insurance program.

Local prepayment plans now in operation must conform to the following standards in order to become part of the new proposed nationwide system:

(1) They must have the approval of the state or county medical society in the area in which they operate.

(2) The medical profession in the area must assume responsibility for the medical services included in the benefits.

(3) The local plans must provide free choice of a qualified doctor of medicine and maintain the personal, confidential relationship between patient and physician.

(4) They must be organized and operated to provide the greatest possible benefits in medical care to the subscriber.

The medical profession is working to perfect a national voluntary health system because it believes that is the only way the American people can continue to enjoy a high standard of medical care. It also believes the American people prefer voluntary action to compulsion. —Anaheim *Bulletin,* March 27.

Private Disability Insurance Stimulated

California's disability insurance act, which hasn't gone into effect as yet, is nevertheless already benefiting buyers of this type of insurance.

It was disclosed today by officials of the State Employment Stabilization Commission that private companies are developing disability insurance plans more liberal than the state's.

Some private plans cost only three-quarters of 1 per cent of a worker's salary per month. And they pay benefits up to $30 a week for 52 weeks.

This is against the state's rate of 1 per cent (or a continuation of the present 1 per cent unemployment insurance tax), and a limitation of 23.4 weeks of benefits.

The private plans weren't always so liberal. In fact, before the special session of the legislature enacted the disability bill this spring, such generous terms were almost unheard of, except for one 52-week, $30 plan in existence for five years.

Stabilization Commission officials are agreeably surprised at this turn of events. There is a clause in the disability bill allowing groups to insure with private companies and stay out of the state act if they so desire.

Frankly, the officials didn't think private companies would make terms attractive enough for many to take advantage of this clause, but they are, says Pat Merrick, who heads a state employment division handling this subject.

Such private plans must get the approval of the Stabilization Commission, but many that have been submitted so far to the division headed by T. H. Mugford, one of the commissioners, appear eligible.—San Francisco *Chronicle*, May 16.

Urges U. S. Care for Mothers, Babies

Dr. Martha M. Eliot urged early congressional action on national health legislation, saying that "each day debate goes on, we lose eight more mothers and 85 more babies needlessly."

Since the bill was introduced last fall, the associate chief of the labor department's children's bureau told the senate labor committee, "more than 13,500 babies and 1,300 mothers have died whose lives might have been saved."

Both she and Secretary of Labor Schwellenbach recommended that care should be provided for all children and expectant mothers, rather than limited to families "insured" under the proposed compulsory health insurance plan.—Sacramento *Bee*, May 1.

Vet Group Backs Compulsory Insurance

Chairman Charles Bolte of the American Veterans' Committee today urged passage of the Murray-Wagner-Dingell bill for compulsory health insurance to provide veterans with the same "modern pattern of medical care" they got in the armed services.

Bolte testified before the Senate Labor Committee, which is considering the bill.

"Most of us found that the medical care we got in the service was as good or better than we ever got before, minor gripes notwithstanding.

"The main reasons it was good were that we got it when we needed it, we got all of it the doctors felt to be necessary, and we did not have to limit out treatments to those we could pay for at the time.

Bolte said AVC had conducted discussions of the Murray-Wagner-Dingell bill at its chapters throughout the country and is overwhelmingly in favor of it."—San Francisco *Chronicle*, May 1.

Congress Opposes Socialized Medicine

A study made by Surveys, Inc., for Look Magazine, of Congressional opinion on a number of vital legislative problems, shows the following: (q) Do you favor Socialized Medicine?

Yes	14.5 per cent
No	81.9 per cent
No opinion	3.6 per cent

Taft Health Bill Would Aid States

A Republican counter proposal to the administration's national health insurance bill would allot $220,000,000 yearly to the states to improve medical and dental care.

Senators Taft, Ohio, Ball, Minnesota, and Smith, New Jersey, joined in offering the bill which they said "places the primary responsibility for the health of the people on the states and local governments."

"We believe that federal funds are necessary," they added in a statement last night, "but only to aid the lower income groups of the population and furnish financial assistance to states and local governments to supplement the limited funds available for help."

The Taft-Ball-Smith measure would bring all federal health activities under a national health agency to be headed by a physician, preferably with cabinet status.—Fresno *Bee*, May 3.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Acts to Lift Hospital Standards

Alameda County's Medical Association plans to impose stringent requirements upon physicians and surgeons practicing in nine of the county's hospitals that exceed standards fixed by the American Medical Association and the American College of Surgeons.

The plan, approved recently by the Association's Council, according to Dr. Warren Allen, president, awaits concurrence by the various hospital managements and, if put into effect, will be aimed at "a higher level of quality in medical and surgical care than has been attained elsewhere. . . ."

"The Association plans," Dr. Allen said, "include the establishment in each hospital of a Board of Medical Review composed of especially qualified general practitioners and specialists whose duty it will be to review and evaluate the results obtained in each case admitted to the hospital.

"The review board in each hospital will require that qualified designated consultation or assistance be obtained in such instances as may be deemed advisable to the best interests of the patient."—Oakland *Tribune*, May 5.

COMMITTEE ON POSTGRADUATE ACTIVITIES

U. C. Plans Medical Refresher Course

The medical faculty of the University of California will give an intensive refresher course in internal medicine at the Medical Center from June 17 to 28 inclusive, under the sponsorship of the American College of Physicians.

It is a postgraduate course for general practitioners, intended primarily for members of the American College of Physicians. Dr. Stacy R. Mettier, associate professor of medicine, is in charge of the program.

Sessions will be held five days a week, Monday through Friday, from 9 a.m. to 5 p.m. Symposia will be given on a wide range of subjects, including endocrinology, the anemias, psychosomatic relationships, pulmonary diseases, arthritis, nutrition, etc.

The Society for Investigative Dermatology

The Society for Investigative Dermatology will resume its annual meetings this year with a gathering June 30, at the Hotel Whitcomb, San Francisco. The two scientific sessions, from 10 A.M. to 1 P.M., and from 2 to 6 P.M., are open meetings and are not limited to members only.

The Scientific Program follows:

Presidential Address: The History of Lupus Vulgaris.

Mechanism of Spontaneous Cure of Tinea Capitis in Puberty.

Somato-Psychic Medicine.

A Histopathologic Study of Cicatrizing Alopecias.

Experimental Aspects of Penicillin Sensitization with Especial Reference to Conjoint Sensitization to Superficial Fungus Disease.

New Surface Active Antibiotics.

Advances in Our Knowledge of the Chemistry of the Skin.

Severe Erythema Bullosum with Grave Constitutional Symptoms.

The Use of the Hormones in Dermatology.

Studies on the Adherence of the Epidermis to the Corium.

Pyribenzamine in Experimental Allergic and Non-Allergic Skin Manifestations.

Melanin Pigmentation Through the Ages.

Systematized Amyloidosis of the Skin and Muscles.

Local Sensitization of the Skin to Grenzrays.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Doctors, Nurses Needed in Vet Hospitals

Announcement of openings for doctors and nurses in California, Nevada and Arizona Veterans' Administration hospitals has been made by Forrest G. Bell, M.D., branch medical director.

Additional doctors up to 70 years of age are needed to rate pension claims of veterans, Dr. Bell said. As medical rating specialists they will have no clinical or hospital responsibilities.

The hospital positions for doctors offer extensive opportunities for research, varied clinical experience, professional advancement and recognition and close association with medical teaching centers.

Salaries are based on the qualications of each doctor. The general range is from $3,640 to $6,230 annually, but there are a few higher salary positions. An additional 25 per cent is paid to doctors certified by one of several American Specialty Boards.

Preference as to location and duty in any one of the nine Veterans' Administration hospitals in the three states will be given every consideration possible.

Doctors and nurses should write or apply to the San Francisco Veterans' Administration Branch 12 office, 49 Fourth Street, or the manager of any V.A. station.

Christmas Seal Sales Increase

Christmas seal sales in California last year topped those in any other state for the third consecutive year, although the State's percentage increase over the preceding year was less than for the nation as a whole.

Final figures released by the National Tuberculosis Association show sales by California Tuberculosis and Health Association at $1,293,535, or 3.6 per cent above the previous year's total, while the national total rose 4 per cent to a new high of $15,572,000.

Second to California last year was Pennsylvania Tuberculosis Society with $1,275,000, while New York State Committee on Tuberculosis was third with sales of $1,049,000.

Nurses' Aides Honored

More than a thousand Red Cross Nurses' Aides were presented certificates of merit at a buffet tea given in their honor May 2 at the Fairmont Hotel, San Francisco.

The certificates were awarded by the San Francisco Hospital Conference in appreciation of the part played by the recipients in enabling civilian hospitals to maintain adequate hospital care during the war years.

Speakers included J. J. Rourke, superintendent of Stanford Hospital; Dr. C. L. Cooley, president of the San Francisco County Medical Association; Mrs. William P. Roth, chairman of the Volunteer Service for the Red Cross, and Mrs. Stanley B. Powell, chairman of the Nurses' Aide Corps.

TB Nursing Institute to Open June 24

The University of California at Berkeley, in coöperation with the California State Department of Public Health, has announced a three weeks' institute on tuberculosis nursing from June 24 to July 12. The course will be conducted by Miss Margaret Taylor, Tuberculosis Nursing Consultant, USPHS, with medical lecturers provided by the Bureau of Tuberculosis, State Department of Public Health. Three units of university credit will be given upon completion of the course.

C.M.A. CANCER COMMISSION

Broader Program for Cancer Control

During this first post-war year the Cancer Commission has been able to resume its activities and to enter upon a larger program for cancer control. The entire program has been presented step-by-step to the Council of the C.M.A. and the commission has been proceeding under the direction and approval of the council.

The commission has started the preparation of a new Cancer Manual to be distributed to the members of the C.M.A. following the pioneer work that was done in 1932-34 and appeared as *The Cancer Commission Studies*. The present manual is in charge of an editorial committee composed of Doctors Dobson, Pflueger and Berne. During the year the commission has made a preliminary survey of the clinics and facilities for the treatment of cancer in California. This is the beginning of an extensive survey which will be conducted next year. In the past few months two of the dormant cancer clinics have been reactivated and four new cancer clinics in approved hospitals are in the process of formation. The commission will be prepared to advise and assist in the formation of necessary cancer clinics throughout the State.

During the year several members of the commission have been requested to speak before meetings of county medical societies. Preparations are underway to coöperate with the Postgraduate Committee of the C.M.A. so that meetings on cancer will be available whenever they are requested. The commission is also contacting the medical schools in California to provide formal refresher courses on cancer. This program is being developed with the coöperation of the California Division of the American Cancer Society.

The Pre-Convention Conferences in Radiology and Microscopic Tumor Pathology were renewed at the annual meeting of the C.M.A. in Los Angeles. In spite of the difficulties attending this first post-war meeting and transportation hazards both conferences were unusually successful. The symposium conducted by Dr. Harry Garland at California Hospital in diagnostic and therapeutic radiology presented many new and unusual manifestations of neoplasms and also the new concepts of radiation therapy. More than fifty pathologists attended the Microscopic Tumor Conference in the Science Building of the University of Southern California under the leadership of Dr. Paul Guttman. The microscopic slides of twenty patients were reviewed in conjunction with histories, clinical findings, and the final diagnoses in these cases.

A new feature in the 1946 annual meeting was the Cancer Commission dinner for the Cancer Committees of the County Medical Societies and for representatives of approved cancer clinics. The guest speakers included Dr. George Pack, Surgeon of the Memorial Hospital in New York, Mrs. Doris Ryer Nixon, State Commander of the Field Army of the American Cancer Society, and Dr. Malcolm H. Merrill, Deputy Director of Public Health. Members of the commission presented informal talks to acquaint the representatives of the county medical societies with the work and program of the commission. The county societies and cancer clinics were invited to bring to the commission their problems in cancer control, as well as to assist the commission in its statewide program.

Cancer Clinics for Fresno

The establishment in Fresno of two cancer clinics for diagnostic and consultative work, seeking to curb the disease, is foreseen by July 1 as officials in charge of the recent campaign for cancer control funds reported the city's collections totaled $15,869.98, far in excess of the $10,400 sought.

Dr. William L. Adams, Jr., the chairman of the clinic committee for the Fresno County Cancer Society, said officials of the cancer commission of the California Medical Association, at a meeting in Los Angeles last weekend, approved plans for the proposed clinic in the Fresno Community Hospital and approved in principle the clinic planned for the Fresno County General Hospital.

Practically Assured

This means, Dr. Adams said, the consultation and diagnostic clinics are virtually assured, subject only to final approval of medical men to be included on the panel of specialists conducting the clinics by the various agencies concerned. This approval is virtually automatic, Dr. Adams said.

"The doctors will be appointed by the hospital staff, their qualifications and sent to the Fresno County Medical Society for approval. The county group in turn will ask for the approval of the county cancer society," Dr. Adams explained. "The recommendations then go to the cancer commission of the California branch of the American Medical Association. Their approval, together with a suggested budget, goes next to the California Association of the American Cancer Society. We foresee no difficulty in obtaining all the necessary approvals.

Hope for Early Start

"Thus, we hope to get something started in the Fresno Community Hospital by July 1st. Very little additional equipment is needed and the panel of specialists who will participate in the work is practically completed."

Dr. Adams said the clinic proposed at the general hospital has been promised by Dr. H. M. Ginsburg, the hospital director, and will involve little more than official approval of the program already functioning there for indigent patients.

Under the plan proposed for the community hospital, Dr. Adams said, all the work necessary for complete diagnosis of suspected cancer cases will be handled, with the following specialists in their fields included on the panel of experts available for consultation:

A surgeon, dermatologist, gynecologist, internist, urologist, radiologist and pathologist. Others will be added as the need for their services develops.

On Cost Basis

The physician reported the fees in the latter clinic will be on a cost basis, with additional financial aid coming from the cancer societies through money collected in the recent drive and future fund raising campaigns.

"This should amount to a considerable saving," he asserted. "The extensive laboratory procedure necessary in diagnostic work is very expensive, and often includes both bacteriological and chemical analysis, as well as the x-ray and other means of determining the presence of the tumorous growths."

The collections reported by Dale Orr, representing the Fresno Exchange Club, sponsor of the drive which closed last week, together with the $5,510 reported from outlying communities, puts the campaign substantially over the mark of $16,000 sought in the month long effort to assure the clinics.

There remains approximately $300 to be collected from pledges in the city drive, which will put the city's total alone over the entire county quota. With some collections still outstanding in the county, officials predicted the over-all total will exceed $20,000.—Fresno *Bee*, May 14.

Cancer Bill Benefits

One of the most forward looking pieces of legislation ever conceived in the interests of suffering humanity is being considered by the house foreign relations committee.

It is the Pepper-Neely bill to appropriate $100,000,000 for a supreme effort to discover means of curing and preventing cancer, which takes the lives of some 170,000 Americans each year.

For a nation which spent $2 000,000,000 on the atomic bomb project and hundreds of billions more in prosecuting the war, this sum is small enough indeed when compared with the benefits which might be achieved.

For example, during the years 1942, 1943, 1944 and 1945 cancer killed at least twice as many Americans as were killed in the war.

The proposed Pepper-Neely appropriation would permit medical science to attack the problem of cancer cure and prevention on the same broad basis as the physicists attacked the problem of unlocking the secrets of nuclear energy for the development of the atomic bomb.

If the medical men should be successful in their research, here is a secret which we willingly could and would give to the world as a contribution to all humanity.

In any event, on the outcome of deliberations on the bill rests the fate of 17,000,000 Americans who may be condemned to cancer deaths.—Editorial in Sacramento *Bee*, May 15.

San Mateo County Clinic Planned

Plans for the establishment of a cancer clinic in San Mateo County were told this week by Mrs. Leonard Wood when she spoke to members of the Lions Club at their dinner meeting.

Mrs. Wood, a member of the San Mateo County unit of the San Francisco Junior League, which has been asked by the American Cancer Society to campaign for funds during April, told Lions members that the clinic, although still in the formative stage, is expected to be completed within a year.

Need for a clinic to combat cancer was brought into sharp relief by the publication of statistics showing the disease casualties during the war years, Mrs. Wood said.

"During the war years more Americans died from cancer," the speaker stated, "than on the battlefields of both the German and Jap fronts."—Redwood City *Tribune*, April 12.

Doctors Urge $100,000,000 Cancer Fund

A group of doctors and scientists urged Congress to provide $100,000,000 for a Government-sponsored cancer control program.

Such action is necessary, the witnesses told the House Foreign Affairs Committee, in order to finance necessary research to halt an increasing rate of cancer.

The committee is considering bills by Senator Pepper (D., Fla.) and Representative Neely (D., W. Va.) to authorize the federally-backed program.

Julius Jay Perlmutter of New York, chairman of sponsors of government action against cancer, told the Legislators the President should be given the money "for an attack on the cancer problem similar to the Manhattan project which produced the atomic bomb."

"It is time that recognition was given to this national emergency," Perlmutter said. "Cancer experts say that 17,000,000 persons are doomed to die in our life time unless a cure is found.

"The appropriation of $100,000,000 is merely $6,000 per person doomed to die.

Other testimony, including statements filed with the committee, included:

Dr. G. Fialla, director of radiological research laboratory, Columbia University: "Ten cancer research centers should be established and financed for a period of at least ten years. At present no scientists can indicate a definite line of attack that will solve the problem."

Dr. Harry B. Friedgood, president, cancer research foundation of California: "It is a well-known fact among those who work in this field that certain aspects of the cancer problem are not being investigated and cannot be investigated because money is not available for the purchase of specialized scientific instruments. The need for legislation is imperative."—San Francisco *Chronicle*, May 8.

CALIFORNIA PHYSICIANS' SERVICE†

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Report of the Trustees to the Administrative Members of C.P.S.

Chester L. Cooley, M.D., *Secretary*

In giving you my report as secretary of the Board of Trustees of California Physicians' Service, I believe you will be interested in reviewing those men who bear the responsibility for the operations of California Physicians' Service. Their names lead this column.

I should like to remind you that C.P.S. is now in its eighth year of operation. We are no longer a little business. We are now big business. I should like to call your attention to the fact that C.P.S. has undergone almost every possible adverse condition since its inception. Let me briefly explain. In the first place, we started with a capital of $42,000 from C.M.A.—which was repaid to C.M.A. three years ago. It should have been $500,000. This needs no further explanation. Then, for nearly five years our country was engaged in a total war. Necessarily, we were forced to insure a large number of 4-F's and women who were obviously poor actuarial risks. And finally, with the sudden ending of the war, with the accompanying labor unrest, we lost beneficiary members almost as fast as we could acquire them. Now, however, things are leveling off and we expect a marked increase in membership during the coming year. We feel sure that C.P.S. is now financially and actuarially sound, and is ready to handle the expected increased business.

I should like to summarize the principal developments during the ten trustees' meetings which were held from May of 1945 to May of 1946.

As you know, the Housing Project Program, in which C.P.S. was providing medical and hospital care to occupants of these projects, was officially closed after three and one-half years on January 1, 1945. Letters from the Federal Public Housing Authority as well as the Chairman of Procurement and Assignment Service, have stated that the medical profession contributed greatly to the war effort in maintaining a high quality of medical care for war workers during this period.

During the early part of 1944 it was recognized that the rates being charged beneficiary members would never return to the doctor the full value of the fee schedule. It was also evident that C.P.S. must place in effect a rate increase to its beneficiary members. After considerable actuarial study by an independent actuary, the Board of Trustees, in November of 1944, voted a 33 per cent increase. Because of unavoidable delays arising from our relationship with the Blue Cross Plans, the rate increase did not start to become effective until March of 1945, and was not completed until March 1, 1946. During the previous 19 months, C.P.S. had been paying a unit value of $2.25, while actually earning much less. During this period we accumulated quite a sizeable deficit. You should realize that C.P.S. fee schedule is from 30 to 60 per cent higher than any other prepaid schedule in the United States.

In May, 1944, the Board of Trustees were instructed to procure a business man as administrative head. A committee of the Board of Trustees was appointed. After searching for one year, the committee decided that we had a man in our own organization that could fill the bill. In the summer, when W. M. Bowman took over, he was faced with many problems, and I am happy to say that the Board of Trustees of C.P.S. are most pleased at the manner in which he has handled the business and administrative affairs of C.P.S. He has more than fulfilled our expectations. We are being given up-to-date financial and actuarial data, as well as other monthly reports on C.P.S. operations. Mr. Bowman will give his business report to you gentlemen in a few moments, and I am sure he will cover many of the questions and problems of C.P.S.

During the past year, we have had several committees studying C.P.S. I should like to name a few of them. The Interim Health Committee of the State Assembly made a complete survey by an accredited actuary, Mr. Virgil Griffin. The Senate Health Committee is also making a study of C.P.S. The Advisory Planning Committee of the California Medical Association has also examined C.P.S. and its various departments. The Indemnity Study Committee of the C.M.A., which was appointed by the House of Delegates at its 1945 session, has made an exhaustive study of California Physicians' Service as well as other insurance plans. The National Physicians' Committee also sent out an actuary who spent several days in the C.P.S. offices. I have talked with a number of these men who have made these surveys, and they have been unable to tell me of anything that is seriously wrong with C.P.S. as a business organization.

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† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen M.D., Medical Director.

Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

I am glad to report to you that the relationship with our member physicians is steadily improving. Mr. Bowman will give you a report on the activity of our Professional Relations Department. I should like to mention that we are now able to furnish service in every county in the State.

Through the efforts of Dr. Madeley, Dr. Frank A. MacDonald. Councilor of the C.M.A. from Sacramento, Mr. Bowman and myself, Sacramento County now has 82 professional members. In Alameda County we have 398 professional members. I believe the general increase of professional members throughout the State is due partly to the development of the Veterans' Program, but chiefly because more physicians are convinced that C.P.S. is now being conducted in a business-like fashion.

Our most serious problem is the lack of a uniform hospital plan with which we can cover state-wide groups. There have been many attempts by the Hospital Associations to get together, but as yet they have failed to do so. It might be necessary for C.P.S. to write its own hospitalization state-wide.

Probably the most important event that has happened in California medicine occurred during February of this year. I speak of the Veterans' Program. California Physicians' Service signed a contract with the Veterans' Administration in Washington, D. C., for the care of veterans for service-connected disabilities in their own home communities by their own physicians. In negotiating the contract, our administration was able to secure the payment of the full C.P.S. fee schedule, which I think you gentlemen will admit is excellent, considering that we are dealing with a government agency. C.P.S. receives an additional 7 per cent for operating expenses.

I do not know whether any of you realize that when the Veterans' Program is in full swing, and the private physicians are rendering care to 1,350,000 California veterans, it will mean a diversion from government medicine to the private practice of medicine of from $10,000,000 to $18,000,000 per year or more. This would not have been possible had it not been for the existence of California Physicians' Service. I think the medical profession in California owe a debt of gratitude to the men who started C.P.S., and who watched it and guided it through its formative years. Men such as Dr. Wilbur, Morton Gibbons, Vince Askey, Sam Ayres, Alson Kilgore, Dewey Powell and Tom Kelly spent their time and their unstinting efforts to develop a constructive program for the profession.

Here are some interesting figures on the Veterans' Program. The total amount of claims during the first month will be over $57,000. In May we estimate that it will run approximately $100,000. To date, 90 per cent of the doctors' claims go through without question. Ten per cent are questioned. and of this, 6 per cent are refused. After six weeks of operation, the dollar claim load of the Veterans' Program is equivalent to adding 100,000 members to our Commercial Program. If we had not had an efficient business organization, C.P.S. could not have handled this tremendous load.

Some physicians have criticized us for using the Veterans' Program in order to force them to join C.P.S. This is untrue. C.P.S. was the only medically controlled plan in California that had the administrative setup to handle the Veterans' Program, and therefore the Veterans' Administration could recognize and contract with C.P.S. We have canceled the $5.00 professional membership fee.

There are many political issues of grave importance involved in this new program. They concern the ability of the medical profession to do a good job. Failure may nullify the place of organized medicine in meeting a national need which the Veterans' Administration has asked the medical profession to answer. There is the other problem, of competition with an expanding government bureaucracy to control the medical care of 10 per cent of the population of this nation. If benefits to families of veterans are eventually included—and the move is on for this through veterans' service organizations—then 50 per cent of the population could come under this program. We are now in an emotional and experimental infancy, but it may well become the pattern of medicine when and if the government is going to pay the bill.

On behalf of the Board of Trustees, we want you to know that each of us on the board realizes his responsibility to the profession. There has been considerable criticism of C.P.S. But, gentlemen, little does the average physician know of the complicated problems involved in the operation of a medical service plan. The trustees work closely with the administration, and are convinced that C.P.S. is being operated properly. With your help and the consideration of the profession, we believe that C.P.S. will be the outstanding medical service plan in the United States.

Thank you.

Business Report to the Administrative Members

W. M. Bowman, *Executive Director*

As you know, during the past year there have been certain changes made in the administrative staff of California Physicians' Service. The new administration took over in the summer of 1945. There was a reported deficit at that time of $111,300. We immediately employed new auditors and office managers, and during the next few months discovered an additional deficit of $167,844.21. This represented a total deficit of $279,144.21 by October, 1945.

This additional deficit came as a complete surprise to the trustees of C.P.S., the Council of the California Medical Association, as well as the new administration. This deficit was due to inadequate estimating and auditing systems, as well as to the delay in placing in effect a rate increase to our beneficiary members. We have completely revised our auditing and estimating systems, and our rate increase is now 100 per cent in effect.

Now, to bring you up to date on our financial position. To repeat, our total deficit was $279,144.21 in October, 1945. On May 1st of 1946, this had been reduced to $137,912.66, a total reduction of $141,231.55 in six months. In other words, during the last six months we have reduced the deficit $23,540 per month.

I should like to point out to you at this time that Michigan Medical Service, in 1942, was $704,000 in the red, and for the same reasons that C.P.S. is. Michigan Medical Service put in effect a rate increase of approximately 15 per cent, and came completely out of the red in 30 months. I think it might surprise you to know that the Blue Cross Hospital Plans throughout the United States have also had very poor financial experience during the past two years. C.P.S.'s rate increase averaged 33 per cent. I am happy to say that C.P.S. will be out of the red within the next few months. I also want to assure you that our new auditing systems and other procedures will not allow for another deficit such as we have had in the past.

Our total membership in our Commercial Plan is 208,192 persons—a net growth of some 81,350 persons during the past year. We are signing new members at the rate of 12,000 to 18,000 per month, and will soon have a quarter of a million persons enrolled. Our monthly income, as well as the membership, has almost doubled during the past year. It is to be remembered that during four years of its seven-year existence, C.P.S. has been through an abnormal period caused by the war. You can readily realize that the floating population California has had during this period, and the problems they brought with them, certainly have reflected themselves in all phases of business as well as C.P.S.'s operations.

Our total monthly income from our Commercial Program along at this time is $287,000 per month, or $3,444,000 per year. When we include the income from the Veterans' Program, our yearly income is $4,128,000. You can see by the figures I have given you that C.P.S. today is a good sized business organization.

Some of you may have heard criticism of the high administrative cost of C.P.S. as compared to other plans. We can furnish examples of Blue Cross Hospital Plans, as well as Medical Service Plans and insurance companies, where the administrative cost runs from 18 per cent to as high as 30 per cent. C.P.S.'s administrative cost, figured in the same manner as insurance companies and the Blue Cross Plans, has averaged 15.5 per cent from May, 1945, to April, 1946—a reduction of 4.5 per cent over our previous year's operations.

The Farm Security Administration Program has been a project which provided care to some 3,000 low-income farm families. Members of this program are being transferred to our regular Commercial Plan. It is the objective of the trustees and the administration of C.P.S. to have all members under one coverage—namely, our Commercial Plan. This will greatly simplify procedures for you and for C.P.S., as well.

C.P.S. has two main offices and 12 district offices. We have 130 full-time employees, and 70 employees who are employed jointly with the Blue Cross Plan here in Southern California. All employees are bonded. We are completely equipped with I.B.M. machines for statistical as well as accounting records. It is safe to say that C.P.S. has more actuarial data on prepaid medical care than any other plan in the United States, as evidenced by the numerous surveys mentioned by Dr. Cooley.

You may be interested in our various departments.

The Sales Department contacts the various employers in California and explains our program to them. It is interesting to note that approximately 30 per cent of the employers are now contributing to the monthly dues of their employees. We have over 4,000 groups in the State.

Our Service Department takes on after the sale and enrollment has taken place, and reopens the group to new employees who have been hired after the original enrollment. The main purpose of the Service Department is to maintain a high percentage of the employees of any group enrolled.

The auditing firm of Lester, Herrick and Herrick, of San Francisco, are the Certified Public Accountants who audit our books annually, as well as spot-check and assist us in inaugurating new systems. We employ two highly competent auditors, two office managers and their assistants. It is their responsibility to work out all office and detail procedures in C.P.S.

The Department of Professional and Public Relations was formed about a year ago, with the idea of better informing the physicians, nurses and secretaries on C.P.S. and its procedures. There are 10 persons in this department—6 in the South and 4 in the North. They have personally contacted over 4,300 physicians, their nurses or secretaries. In their contacts they leave a brochure which completely outlines C.P.S.'s procedures. This department has proven very successful. There are now over 6,500 physicians who are members of C.P.S. Over 1,028 new physicians have become member physicians during the last year. We are planning to send each month to the member physicians a news letter which will keep you fully informed on C.P.S. In the exhibits, there is a C.P.S. booth. We should be very pleased to have you stop and see our exhibits, and ask any questions that you might have in mind.

The men in the Professional and Public Relations Department also serve as public relations men, and have given over 460 talks before service clubs and other civic organizations, explaining to these groups the value of voluntary health coverage as compared to compulsory medical care. They have also appeared, by invitation, at numerous County Medical Society meetings.

Our San Francisco and Los Angeles Medical Departments are under the supervision of full-time doctors of medicine. With our increased membership and the Veterans' Medical Care Program, this department is becoming more and more important to the profession who are C.P.S. members. We believe that doctors of medicine should determine and pass on complicated and involved medical cases, and not laymen.

In the fall of 1945, the California State Grange became interested in a coverage for their members and their dependents. We have offered them, and a contract has been signed to provide them with, our regular surgical and hospital plan. As we gain experience on this large farm group, perhaps medical coverage can be added. This is the first time in the history of California that the medical profession and a group of farm people, as represented by the California State Grange, have joined in a mutual fight against compulsory medical care.

The Board of Trustees have been most coöperative, and have always assisted the administration in every possible way. The Board of Trustees and the Council of the California Medical Association are being given up-to-date financial and actuarial information, as well as other reports pertinent to the operations of California Physicians' Service.

In closing, I should like to assure you, Mr. President and Administrative Members of California Physicians' Service, that C.P.S. is coming along in good shape. Many constructive changes have been made in C.P.S., and more are to follow. I can assure you that C.P.S. is now on a sound financial and business basis, and the support that we need most for a more successful C.P.S. is that of a unified profession.

Thank you.

Compulsion Isn't the Way

More than a year ago the Governor of New York state directed the New York Commission on Medical Care to devise a plan to make medical care more available to all classes of people in the State of New York. It became apparent to the commission that the "insurance or payment principle was the one which could best attain this objective" — in other words, compulsory health insurance. But after fifteen months of study, the commission rejected the idea. Three important reasons for the commission's rejections were: (1) the estimated cost of such a program—between $400,000,000 and $600,000,000—was considered excessive, requiring a minimum per capita tax of $45; (2) the people of New York could be expected to regard as an unnecessary bureaucracy the machinery required to run the program; (3) the majority of the commission believed that a public health program might lead to a deterioration in medical service."

Broad, compulsory measures are not the answer to the nation's health needs. Some way must be found to reach the goal of all-inclusive, high-grade medical care without saddling the people with a hopeless maze of bureau-infested red tape and exorbitant social security taxes. The medical profession is working steadily toward that goal by the development of a nationwide voluntary health system.—Editorial in Westwood *Sugar Pine*.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

American Medical Association. The next annual session of the American Medical Association will be held in San Francisco, July 1-5, 1946. (Monday-Friday, inclusive.)

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of these of the Army and Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick or proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical service and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Ed. Note.—Interpretative comments on principles included in the A.M.A. platform appear in CALIFORNIA AND WESTERN MEDICINE for December, 1939, on pages 394-395. For subsequent comment, see *J.A.M.A.*, June 24, 1944, pp. 574-576. Also, August, 1945, CALIFORNIA AND WESTERN MEDICINE, pp. 61-62.) On p. 61 (C.M.A.) and p. 62 (A.M.A.)

Medical Broadcasts*

C.M.A. Radio Program Announcements:

Packets of cards announcing "California Caravan," new radio program of the California Medical Association, have been sent to members with a request from Sam J. McClendon, Association president, that each member enclose cards in bills to patients this month and next.

The program, part of the C.M.A. campaign to inform the public of the benefits of voluntary health insurance as opposed to compulsory state medicine, will be aired each Saturday night at 9:15 by 17 California stations in the Mutual Don Lee Network.

⁂

Los Angeles County Medical Association:

In June, KFAC will present broadcasts on Saturdays at 10:15 a.m.; June 1, 8, 15, 22, and 29.

Pharmacological Items of Potential Interest to Clinicians*:

1. *American Chemical Society* meeting in Atlantic City April 8-12 offered medicinal chemistry program rivaling that of Federation of American Societies for Experimental Biology held month previously: symposia included nutritive value of protein hydrolyzates, microbiology, anti-malarials, clinical biochemistry, enzymes, metabolism of acetic acid, vitamins, premedical education, pharmacological agents, and biochemical and biophysical studies on viruses. But commercially inspired official hush on penicillin continues.

2. *Therapeutic Notes:* W. W. Zuelzer and F. N. Ogden find 5 mgm. folic acid daily by mouth specific for megaloblastic macrocytic anemia (*Proc. Soc. Exp. Biol. Med.*, 61:176, 1946). D. State and O. H. Wangensteen recommend procaine intravenously, 1 Gm. in 500 cc. physiological saline solution, in treatment of delayed serum sickness (*J.A.M.A.*, 130:990, April 13, 1946). E. A. Brown & Co. recommend 2 per cent carbamide peroxide in 50 per cent glycerol and water as safe and effective topical antiseptic (*New Eng. J. Med.*, 234:468, April 4, 1946). B. L. Coley & Co. review bacterial toxin therapy of malignancy (*Cancer Res.*, 6:205, 1946).

3. *Of Cultural Interest:* McGraw-Hill, 330 W. 42nd, N. Y. 18, announces *Science Illustrated*, large sized jazz science monthly at $3 annually. Froben Press, 4 St. Luke's Place, N. Y. 14, offers W. Marmelszadt's *Musical Sons of Aesculapius*, illustrated at $3. J. B. Lippincott, Philadelphia 5, issues D. Guthrie's *History of Medicine*, 448 pp., illus. at $6. A. A. Knopf publishes A. Castiglioni's *Adventures of the Mind*, 448 pp., illus. at $4.50. MacMillan, 60 5th Ave., N. Y., issues A. S. Eve's *Rutherford*, a significant biography, 451 pp. at $5. A. Kardiner's *Psychological Frontiers of Society* appears from Columbia University Press, N. Y., with 475 pp. at $5.

4. *Enzymes and Growth:* D. Grob well discusses control of activity of proteolytic enzymes (*J. Gen. Physiol.*, 29:219, 249, 1946). W. Shive & Co. study competitive analogue-metabolite growth inhibitions, and suggest product inhibition index as molar ratio of analogue to metabolite at which rate of synthesis of product is reduced enough to prevent growth of organism in medium free of product (*J. Biol. Chem.*, 162:451, 463, 1946). F. Schlenk & Co. note inactivation of glutamic-aspartic transaminase by sunlight and ultraviolet, not x-ray (*Proc. Soc. Exp. Biol. Med.*, 61:183, 1946). Our C. E. Lankford and P. K. Skaggs report cocarboxylase as a growth factor for gonococci (*Arch. Biochem.*, 9:265, 1946). P. R. Cannon & Co. demonstrate importance of protein reserves for antibody production (*J. Immunol.*, 52:267, 1946).

5. *Symposia and Reviews:* W. B. Dublin neatly reviews knowledge of reticulum (*Arch. Path.*, 41:299, 1946). L. J. A. Parr and E. Shipton offer full review of rheumatic spondylitis (*Med. J. Austral.*, 1:277, March 2, 1946). Note excelletn symposium on radiobiology (*Brit. Med. Bull.*, 4:1-65, 1946). E. M. Hildebrand introduces general symposium on weed destruction, important in pollen and allergy control (*Science*, 103:465, 469, 472, etc., April 19, 1946).

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† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week. In CALIFORNIA AND WESTERN MEDICINE, some rosters appear in every second or third issue.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

6. *Otherwise:* H. H. Anderson & Co. report physical and biological properties of subtilin (*Science*, 103:419, April 5, 1946). T. F. Gallagher & Co., E. C. Kendall & Co., E. S. Wallis & Co., go to work on synthetic steroids (*J. Biol. Chem.*, 162:491, 555, 633, 1946). D. E. Abreu & Co., offer neat biochemorphic study of thiophene analogues of trasentin (*J. Pharmacol.*, 86:208, 1946). R. H. Goetz (Cape Town) describes rate and control of blood flow through skin of lower legs (*Amer. Heart J.*, 31:146, 1946). H. S. Simms shows log increase in mortality as manifestation of aging (*J. Gerontol.*, 1:13, 1946). J. Furth finds thymectomy reduces incidence of leukemia in high leukemia strain mice, probably by removing potentially malignant cells (*Ibid.*, p. 46). J. E. Ayre and W. A. G. Bauld report low thiamine with high estrogen is dangerous precancerous combination (*Science*, 103:441, April 12, 1946). E. R. Loew & Co. give pharmacological data on benadryl (*J. Pharmacol.*, 86:229, 1946). Our C. N. Frazier and E. H. Frieden discuss action of penicillin (*J.A.M.A.*, 130: 677, March 16, 1946). H. K. Faber and R. J. Silverberg find pharynx favorable site for primary penetration of polio virus and primary lesion in peripheral ganglia (*J. Exp. Med.*, 83:329, 1946). E. C. Dodds discusses ancient apolthecaries and modern biochemists (*Lancet*, 1:221, Feb. 16, 1946). D. Guthrie offers *A History of Medicine* (Lippincott, Philadelphia, 448 pp., 1946, $6). A Castiglioni offers *Adventures of the Mind* (Knopf, N. Y., 428 pp., 1946, $4.50).

Leprosy in San Francisco.—Nineteen local cases of leprosy have been reported in San Francisco in the past 16 years, according to Dr. J. C. Geiger, director of public health for that city.

A table showing by years the number of cases reported in the period 1930-45 follows:

1930	4	1937	3
1933	2	1938	2
1934	1	1932	1
1935	2	1943	1
1936	1	1944	1
1945	1		

From the data shown in reporting, the following segregations have been made:

Sex: 17 male; 2 female.

Race: 12 white; 7 Chinese.

Onset: The time interval from onset date to date of reporting varied. The shortest interval was three months, the longest 12 years. Three cases did not show date of onset.

Prizes for Students' Theses.—"The Rôle of Hormones in Sterility" is the subject for theses offered in competition for the Schering Award of 1946 in a thousand dollar prize contest open to undergraduate medical students.

For the best thesis submitted, an award of five hundred dollars will be given, and for the second and third best papers the awards will be three hundred and two hundred dollars, respectively.

Sponsored by Schering Corporation of Bloomfield, New Jersey, the award contests are held annually to encourage medical students to acquire further knowledge of various fields of endocrinology.

Three judges, each prominent in endocrinology, will make this year's selections.

Dengue Fever Vaccine.—An effective vaccine has been obtained against dengue fever, it was announced recently by the Commission on Neurotropic Virus Diseases of the Army Epidemiological Board.

This malady, which occurs in epidemics and sometimes pandemics through the warmer portions of the temperate zone, is due to a filterable virus. It is characterized by an intermittent fever, rash on the skin, and often excruciating pains in the joints.

The virus first was isolated in Hawaii by Army doctors and brought to the United States where it has undergone 32 consecutive passages through the brains of mice. In the course of these passages it underwent a curious mutation, whereby it has lost its capacity to produce in men the severe illness and protracted fever characteristic of the original disease. It has retained, however, its ability to produce the measles-like rash and it gives subsequent immunity to the unmodified dengue virus. The immunizing dose is very small. The extract from the brain of a single mouse has been found to contain at least 10,000 such doses. The new vaccine is prepared from this modified virus.

There remains the possibility that there may be several strains of the dengue virus—as is known to be the case for several other viruses, such as that which causes influenza. However, two additional virus samples brought from India have been found immunologically identical with the original Hawaiian strain. Repeated attempts have been made to isolate still another strain by inoculating volunteer human subjects with sera obtained in the Philippines and Okinawa during apparent dengue outbreaks. These have been unsuccessful.

It also has been found possible to propagate in chick embryos the dengue virus after about 18 passages through mouse brains.

Two strains of alleged dengue virus obtained from Japan have been found quite different from the Hawaiian and Indian strains—different, in fact, from any other known virus.

Salvaged Red Blood Corpuscles Used.—Salvage of red blood cells now largely discarded in the preparation of plasma was suggested today by Dr. Max Strumia of Bryn Mawr Hospital as a means of producing a blood fraction capable of treating certain human ailments.

Strumia told the American College of Physicians at its twenty-seventh meeting that he and a group of researchers in his hospital have developed a method of producing from discarded red cells a blood protein called "globin."

Explaining that the substance has been used successfully in the treatment of wound shock and in the relief of a condition wherein excessive fluid is left in the body during cases of kidney disease, malnutrition and cirrhosis of the liver, Strumia declared that the substance cannot be prepared economically by the average laboratory and at present is available only experimentally.

He added: But it is hoped that it will be available for general distribution in the near future.—Sacramento *Bee*, May 14.

New Residents for Palo Alto Hospital.—The first of three resident doctors assigned to the Palo Alto Hospital through arrangement with the Stanford Medical School is taking up his duties following his release from Navy duty, it was announced today.

He is Dr. William Clinite, Stanford graduate, whose special field is surgery. A specialist in medicine will be added to the resident staff next Monday and a third man, a gynecologist and obstetrician, will come in the near future.

The presence of the resident doctors at the hospital, it is pointed out, eliminates delay in securing emergency treatment and relieves other physicians of the community from emergency duty except where their services are requested by the patients.

The resident personnel will be rotated every three months with the San Francisco City and County Hospital-Stanford Service, and Stanford-Lane Hospital.

Dr. Clinite was graduated from Stanford Medical School in 1939, interned in the San Francisco City and County Hospital, and spent two and a half years at the county hospital in Tulare before entering the Navy in 1942.

During his 35 months of sea duty he handled general Navy practice and battle casualties. At the time of his release from active duty he was a lieutenant commander.—Palo Alto *Times,* April 11.

Radium Society Meeting Changed.—Dates previously announced for the annual meeting of the American Radium Society are incorrect. The meeting will be held in the Assembly Hall in the San Francisco Health Center on June 29 and 30, Saturday and Sunday.

Sacramento Health Officer Recommendation.—A group of Sacramento physicians are urging the hiring of Dr. Albert F. Zipf as the full-time health officer of both Sacramento City and Sacramento County.

The local doctors are suggesting to city councilmen and City Manager Sherwin that Dr. Zipf, new county health officer and acting city health officer, be given the full-time city post, and that a contract be made with county supervisors so that he can act as county health officer.

This would reverse the present contract between supervisors and the council whereby Dr. Zipf has been temporary city health officer on a six months basis, which will expire June 30.—Sacramento *Union,* April 26.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Vaccination Centers Care For 150,000

City Using Latest Type Technique to Combat Smallpox

Emergency hospitals, clinics, health centers and doctors' offices continued to be crowded today with persons seeking smallpox vaccinations, as Health Director J. C. Geiger estimated that some 150,000 San Franciscans have been inoculated this week.

All naval personnel stationed in San Francisco, and within a 50-mile radius was ordered vaccinated. The order applied to naval personnel entering or leaving San Francisco, and included a recommendation that their dependents, as well, take the precautionary measure.

The 12th Naval District order explained that the eight local smallpox cases which have precipitated the immunization campaign were an Oriental type of the disease against which ordinary smallpox vaccine, given all naval personnel when they enter the service, is no protection.

New Vaccine Used

For this reason, a new type of vaccine is being used to fight the smallpox, believed introduced from overseas.

Dr. Geiger said the city emergency hospitals and clinics are using the same type vaccine as the Navy—"the latest type, which will protect against most cases."

The five emergency hospitals have each vaccinated some 1,500 persons a day this week, Dr. Geiger estimated.

"We are using every available force to meet the demand for vaccinations—doctors, nurses, stewards," Dr. Geiger declared. "Every medical facility is in use.

"San Francisco is going to be the best protected city against smallpox that the world has ever seen."

Dr. Geiger said he expected the demand for vaccinations to slack up next week, due to the great numbers of people who are now protected. He found the most "startling" aspect of the campaign to be the large numbers of people who had never had any smallpox vaccinations.

Army public relations officers said they had received no word of a vaccination order similar to the Navy's.—San Francisco *News,* March 23.

Navy Hampering Control of Vice in San Francisco, Dullea Charges

Lack of Navy coöperation in vice investigations hampers police control of prostitution, Police Chief Dullea charged yesterday at Fresno at a conference of the Statewide Committee on Law Enforcement.

He elaborated upon this charge on his return to San Francisco.

Street walkers and women operating out of "both dives and swank cocktail lounges" confine solicitation primarily to Navy personnel and avoid civilian and Army men because they fear arrest, the chief said.

Regarding reports that 485 new cases of venereal disease were listed in San Francisco during March, Dullea stated:

"A breakdown will show many of them are Navy personnel, and yet the Navy has done the lousiest job in vice control ever done in this State and has refused to assign Navy personnel to vice investigation as the Army has done."

A statement in reply was issued by the Twelfth Naval District information office, declaring "no official reports have been received on this charge."

"This Naval District has and will continue to coöperate 100 per cent to the extent of its legal authority in all matters affecting communities in which Navy and Marine Corps personnel reside."

Venereal disease is not an offense in the Navy unless infected personnel have failed to report to a prophylaxis station and have concealed the infection.

Dullea asserted the Army furnishes undercover vice investigators and that Army men testify against venereal sources, whereas Navy personnel are not obliged to do so.

He also protested Department of Health policies which, he said, permit an infected woman to be treated as a sick person, not a subject for jail imprisonment.

"We think infected prostitutes should be jailed as offenders and sentenced to serve long enough to assure no spread of infection," he added.

The committee, of which Dullea is chairman, urged a conference with State Health Department officials to seek added coöperation in combating venereal disease, principally on exchange of information on sources of contact.

Continuation of a general wartime suppression of houses of prostitution also was advocated.

Dr. J. C. Geiger, city health director, reported:

"I do not know of a single instance in which the Navy failed to coöperate in curbing venereal disease. They have coöperated in providing sources of infection every time we have asked."

He said he could not agree to imprisonment for venereal disease cases solely on that count, but "prostitution is something else again; that is the job of the police, and punishment is up to the courts.

"There has been every kind of coöperation in trying to curb venereal disease and still the rate goes up. I doubt if any police chief can solve the problem; Moses couldn't," he added.—San Francisco *Chronicle,* April 12.

MEDICAL JURISPRUDENCE†

Hartley F. Peart, Esq.
San Francisco

Privileged Communications Between Physician and Patient in California

Part III

(Continued from last issue)

Criminal actions proper. The general rule in California is that the physician-patient privileged communication rule is limited to civil actions and cannot be invoked in criminal cases. The statutory basis for this rule is found in Subdivision 4, Section 1881 of the *Code of Civil Procedure,* where it is stated that a "licensed physician or surgeon cannot, without the consent of his patient, be examined in a *civil action* . . ." There is no such statutory provision with respect to *criminal* actions. The basis and purpose of the privilege is to protect a patient from humiliation and annoyance which might follow a disclosure of his bodily ailments, but not to shield a person charged with crime. Thus, in *People vs. Lane* (1894), 101 Cal. 513, where, after a defendant was charged with murder, the doctor who had treated the defendant was called and examined by the prosecution. It was held that the doctor's testimony was admissible, the Court saying that "the rule as to privileged communications between a physician and patient does not apply in criminal cases. The privilege was not conferred to shield a person charged with the murder of another, or to be used as a weapon against one charged with crime." Again in *People vs. West* (1895) 106 Cal. 89, the California Supreme Court stated that the rule as to privileged communications between patient and physician is limited to civil actions and does not apply in criminal cases. Therefore, both from the standpoint of statutory and case law, it can be concluded that in a criminal action proper, a physician cannot refuse to disclose information which was necessary to enable him to prescribe or act for the person on trial for a crime.

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† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

Criminal preliminary hearings, investigations and grand jury inquiries. Whether or not the rule that a physician in a criminal action must disclose all communications between himself and a patient extends to a situation involving a criminal investigation, preliminary hearing or a proceeding before a grand jury inquiring into suspected criminal acts, is unsettled in California. A search reveals no California case in which a question of the applicability of the physician and patient privilege to the enumerated proceedings has been directly passed upon. However, a California Appellate Court decision casting some light on this situation is *People vs. Dutton* (1944) 62 Cal. App. 2nd 862, wherein it was held that the statutory rule prohibiting a physician from disclosing communications made to him by his patient did not extend to a phychiatrist employed as a member of the police forces to interview persons arrested on sex charges. The California Court stated "the claim of privilege as between physician and patient is limited to civil cases and is not cognizable in a *criminal proceeding.*" The use of the words "criminal proceeding" by the California Court in the Dutton case should not by any means be interpreted as holding that a criminal investigation, preliminary hearing or a grand jury inquiry are all "criminal proceedings" and therefore within the rule that a physician may disclose confidential communications in a criminal action. It is suggested that the California Appellate Court in using the words "criminal proceeding" had in mind only a criminal action, or criminal trial proper and did not intend to extend its decision to encompass criminal preliminary hearings, investigations or grand jury inquiries. Clearly a decision going to that extent might possibly expose the physician to liability for disclosing confidential communications. For not all of the above mentioned proceedings always ultimately result in a criminal action proper and therefore if the physician gave evidence in a criminal preliminary hearing, investigation or grand jury inquiry and no criminal charges were actually instituted against a defendant, the physician conceivably could be held liable by a patient for an unauthorized disclosure of privileged communications. Of course, if the physician could obtain a written consent to divulge the communications from the patient, this would provide adequate protection from any future actions by the patient. It would appear that the only safe practice for a physician is to refuse to give evidence concerning confidential communications between himself and his patient except in a criminal action proper unless the patient gives his written consent.

Conclusion. In conclusion and to summarize, it can be stated that in California a physician cannot, without the consent of his patient, be examined in a civil action as to any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient unless the facts of his situation actually bring him within one of the following six classifications: (1) Where a patient sues for damages for personal injuries, any physician who "prescribed for or treated" him may testify; (2) Where a patient is dead, and the executor or administrator, surviving spouse or children sues for wrongful death, the physician may testify; (3) Where the patient is dead and his will is contested; (4) Where the patient is dead and an action is brought involving the validity of any instrument transferring real or personal property claimed to have been executed by him in which case the physician may testify as to mental condition and disclose any such information and; (5) Where, under the Workmen's Compensation Act, the physician makes or is present at any examination of the injured employee; (6) Where the physician is called to testify in a criminal trial proper.

To conclude this article, it may be noted in passing that the law of England on the subject of physician and patient privileged communications consistently through hundreds of years, in direct contrast to the laws of California, has been that "medical men are bound to reveal confidential communications made to them in their professional character as such." *Rex vs. Gibbons* (1872) 1 Car. and P. 97.

(The End.)

National Mental Health Bill

A measure has been introduced into the Senate and House of Representatives at Washington which provides, within the framework of the United States Public Health Service, a national psychiatric institute for research into the prevention, cause, diagnosis and treatment of psychiatric disorders; for the training of qualified personnel throughout the country; and for financial assistance to states, counties and localities which will enable them to initiate adequate preventive mental health facilities.

State health authorities are to present plans for approval of the Surgeon General and to administer state mental health programs in all states where no designated state mental health authority exists.

The problem of the returning veteran suddenly has thrown into bold relief the inadequacy of the nation's mental health facilities. This inadequacy is not the result of the warborne increase in psychiatric disorders alone. For years the campaign for mental health has struggled against immense odds—the geographical isolation of mental hospitals, the slow conversion of asylums into hospitals maintaining advanced modern medicine, the social stigma attached to mental deficiencies or even to minor emotional disturbances, the unwillingness of people to accept mental health as a concomitant of physical health, laws affecting the mentally ill based on criminal procedure, the indifference of medical schools to training psychiatrists, and the poor financial support limiting research and the training of personnel.

Mental health authorities see as the solution to this problem an over-all national mental health program, sponsored by the Federal Government but calling on the best private abilities in the country and abroad.

Such a program is aimed at in Senate bill 1160 the House of Representatives bill 4512. In the House, the bill has been reported favorably by the committee to which it was referred. Hearings will soon be held by a committee of the Senate.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIX, No. 6, June, 1921

EXCERPTS FROM EDITORIAL NOTES

The Semi-Centennial of the State Society.—The fiftieth annual session of the Medical Society of the State of California, held in San Diego on May 10-12, was notable in many respects. . . .

The House of Delegates decided to extend the time of the annual session to four days, and the next meeting in May, 1922, was set for the Yosemite. With better than one in five of the membership in attendance this year, at San Diego, and with a growing recognition on the part of everyone of the value and pleasure of these conventions, a record-breaking attendance can be confidently predicted for next year. . . .

League Luncheon at Coronado.—The San Diego Union of May 12, in a lengthy article, describes the League Luncheon as the outstanding feature of the Fiftieth Annual Convention of the State Medical Society. "More than one thousand medical men and their wives packed the dining room of the Hotel Del Coronado at the meeting of the League for the Conservation of Public Health, and noted speakers vigorously attacked 'quackery' in all its forms, and urged continuous progressive effort on the part of the medical profession to protect the sick and infirm from imposition by incompetent pretentious cultists."

Dr. Smith reviewed the successful work of the League against Social Health Insurance in the 1918 campaign, the legislative battles of 1919, the State-wide campaign of 1920, and the recent contests at Sacramento, during which the League decisively defeated the formidable forces arrayed against modern medicine. As Dr. Smith's address will be published in an early issue of the Journal, further comment is unnecessary at this time. . . .

Commercial Vitamin Preparations.—It seems necessary to call attention to the considerable number of commercial preparations of vitamins now (in this year 1921) being advertised, and with reference to which doctors are being extensively circularized. Vitamins are necessary articles of diet. Deprivation of vitamins leads to disturbed physiology and, if continued, to definite disease. At least three types of vitamins are recognized and few, if any, single preparations or foods contain all of them. But we must not forget that vitamins are unstable, illy-defined chemical substances of still doubtful nature and properties, and that their isolation is attended with difficulty, and their standardization is thus far unsatisfactory, to say the least. Moreover, under ordinary conditions an abundant supply of vitamins is secured from a usual dietary, and no specific addition is necessary. Apply all of these facts to the widely-advertised preparations now being exploited, and then see if you are helping the cause of science or the interests of your patient by prescribing indiscriminately substances which are lauded by commercial interests. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Medical Aspects of Visceroptosis," by George E. Ebright, M.D., San Francisco.—Viscerop-

(Continued in Front Advertising Section, on Page 24)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M.D.
Secretary-Treasurer

Board Proceedings

A regular meeting of the Board of Medical Examiners will be held at the Native Sons Hall, 414 Mason Street, San Francisco, from June 10th to 13th, 1946.

At this meeting, hearings will be held, petitions for modification of terms of probation will be considered, as well as petitions for restoration of revoked certificates.

Written examinations for all classes of candidates licensed by the Board of Medical Examiners will be held starting Tuesday, June 11th, and continuing through Thursday, June 13th.

Pending in the Superior Court in San Francisco, are the applications of three doctors for writs of mandate to compel the State Board of Medical Examiners to issue licenses permitting them to practice in California. The three doctors are graduates of the Chicago Medical School, said school not being on the list of those approved by the Board of Medical Examiners of the State of California as qualifying their graduates for licensure in this state.

Recently the Board of Medical Examiners has had an increase in the number of applications being filed by graduates of schools not approved by the Board. Many of the applicants have served with satisfaction in one of the branches of the Armed Forces. It is to be noted that the Armed Forces have made no distinction regarding the school of graduation in accepting Medical Officers in the Armed Forces, and that there are graduates of schools not approved by the American Medical Association that have been accepted. The Board of Medical Examiners has considered these applicants, but can find no reason to accept them as the California Law definitely states that all applicants must be graduates of a school approved by the Board. Incidently, it should also be noted that hospitals in California training internes should not accept graduates from schools not approved by the California Board of Medical Examiners. (See Section 2147.5 of the Business and Professions Code.)

News

"High Court Reverses Ruling On Doctor—The Fourth District Court of Appeals late yesterday set aside a writ of mandate ordering the State Board of Medical Examiners to dismiss license revocation proceedings against Dr. G. Carl H. McPheeters, Fresno physician and surgeon, and granted the State's motion for a change of venue for further hearing to the Sacramento County Superior Court. . . . The decision reversed the judgment of Superior Judge Dan F. Conway who September 8th issued a writ of mandate which directed the State Board to dismiss the proceedings against the Fresno doctor for asserted lack of prosecution. . . . While oral arguments were heard on the State's motion for a change of venue and Dr. McPheeter's petition for a writ and written briefs later submitted to Judge Conway, the upper court found there is no record to indicate any default was taken or that evidence was taken in support of allegations to the petition. . . . The action of the appellate court places Dr.

(Continued in Back Advertising Section, on Page 40)

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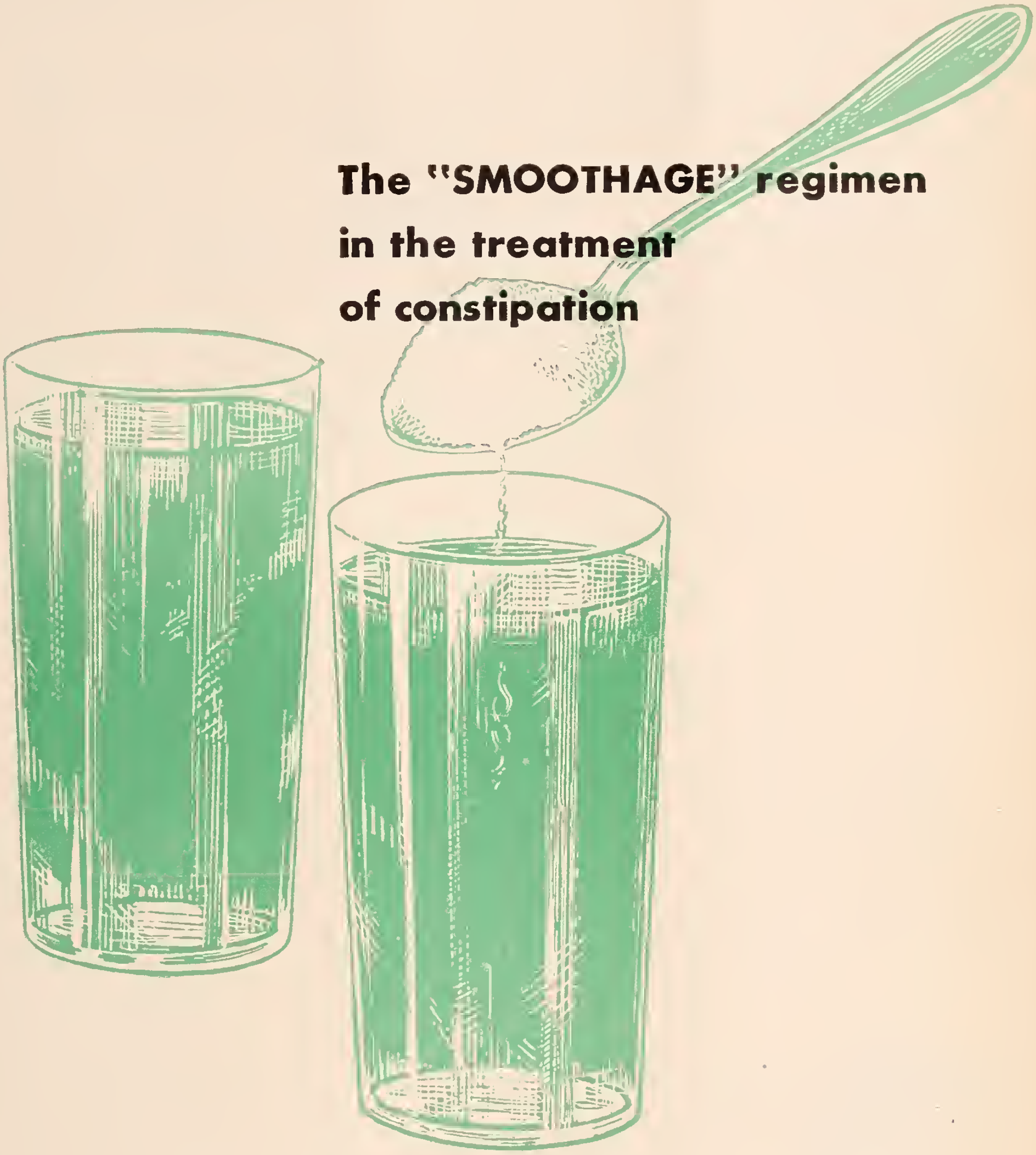
† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

The "SMOOTHAGE" regimen in the treatment of constipation



A rounded teaspoonful of Metamucil stirred into a glass of water, milk or fruit juice, three times a day, provides the soft, mucilaginous bulk which is desirable for natural elimination. Metamucil contains no roughage, no oils, no chemical irritants.

Metamucil is the highly purified, nonirritating extract of the seed of the psyllium, Plantago ovata (50%), combined with anhydrous dextrose (50%). It mixes readily with liquids, is palatable, easy to take.

Supplied in 1-lb., 8-oz. and 4-oz. containers.

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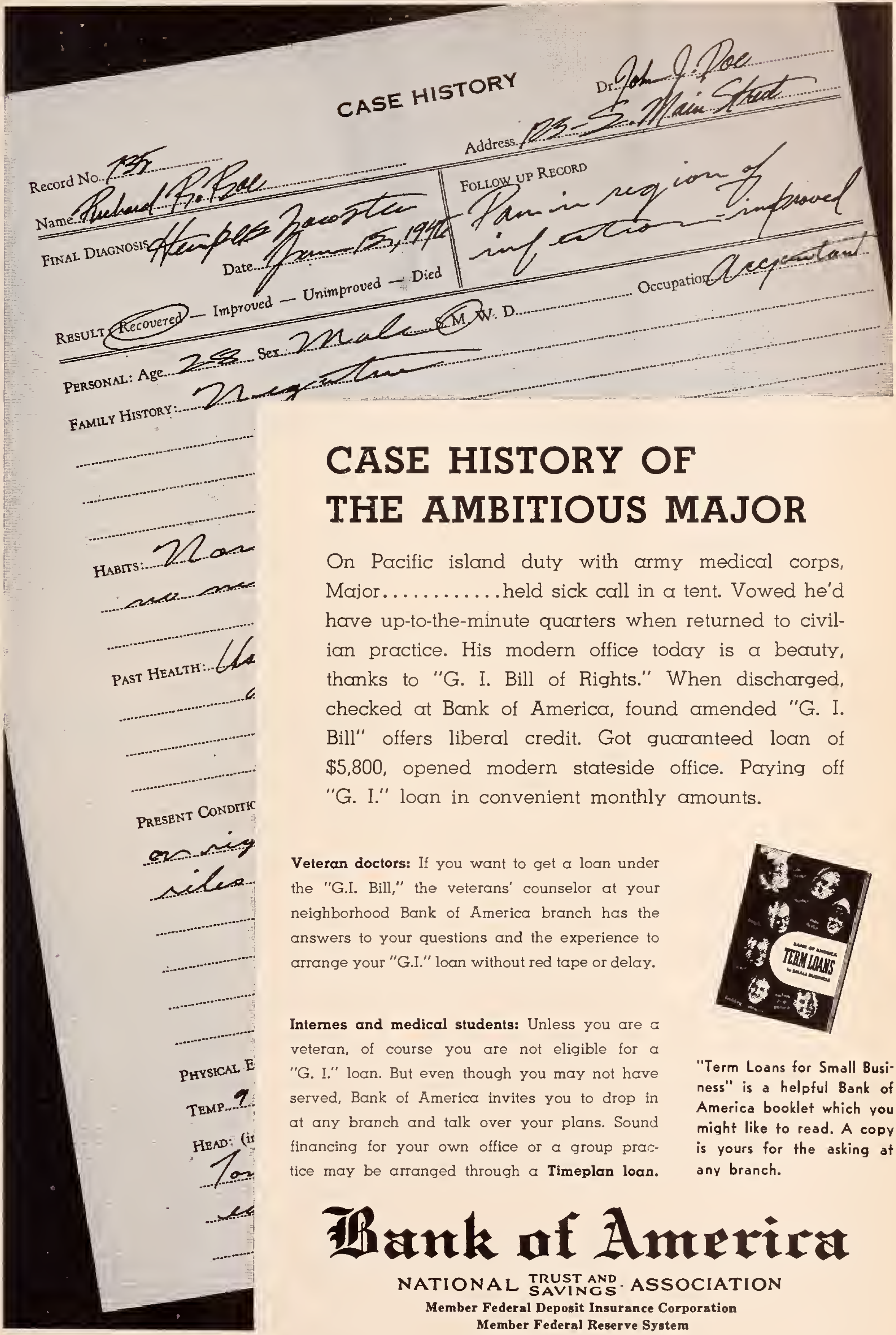

CASE HISTORY

Dr. John J. Doe

Address 123 S. Main Street

Record No. 135

Name Richard R. Roe

FOLLOW UP RECORD Pain in region of infection—improved

FINAL DIAGNOSIS Herpes Zoster

Date June 15, 1946

Occupation Accountant

RESULT [✓ Recovered] — Improved — Unimproved — Died

PERSONAL: Age 28 Sex Male [✓ S] M. W. D.

FAMILY HISTORY: Negative

HABITS:

PAST HEALTH:

PRESENT CONDITIC

PHYSICAL E

TEMP.

HEAD: (i

CASE HISTORY OF THE AMBITIOUS MAJOR

On Pacific island duty with army medical corps, Major............held sick call in a tent. Vowed he'd have up-to-the-minute quarters when returned to civilian practice. His modern office today is a beauty, thanks to "G. I. Bill of Rights." When discharged, checked at Bank of America, found amended "G. I. Bill" offers liberal credit. Got guaranteed loan of $5,800, opened modern stateside office. Paying off "G. I." loan in convenient monthly amounts.

Veteran doctors: If you want to get a loan under the "G.I. Bill," the veterans' counselor at your neighborhood Bank of America branch has the answers to your questions and the experience to arrange your "G.I." loan without red tape or delay.

Internes and medical students: Unless you are a veteran, of course you are not eligible for a "G. I." loan. But even though you may not have served, Bank of America invites you to drop in at any branch and talk over your plans. Sound financing for your own office or a group practice may be arranged through a **Timeplan loan.**

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TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 28)

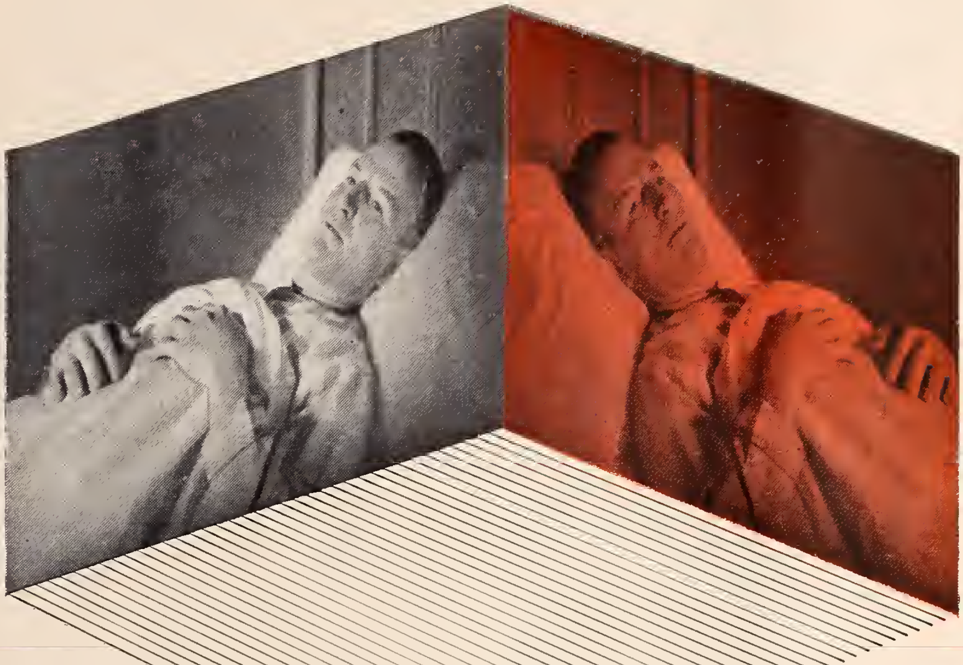
From an Article on "Amebic Abscess of the Liver," by P. K. Gilman, M.D., F.A.C.S., San Francisco, Calif.—Too often considered a disease limited to tropical or subtropical localities, amebic abscess of the liver is not rare in many parts of the United States. Two cases have come to operation in the surgical clinic at Stanford University in this city during the past ten months, two more in private practice and there are at least three localities in this state from which several cases of amebiasis have come for diagnosis and treatment. . . .

From an Article on "Organized Medicine for the Masses a Feature of Present-Day Medical Practice," by E. W. Cleary, San Francisco.—I will discuss Medical Organization from the viewpoint of a doctor, and also in so far as professional bias will permit me to get his position, from the viewpoint of the layman who desires the best that modern medical science can offer.

At the opening of the Cleveland Clinic, Dr. Wm. J. Mayo said, "Our failures as a profession are the failures of individualism. Medicine's place is fixed by its service to mankind. If we fail to measure up to our opportunity, it means State Medicine, Political Control, Mediocrity, and loss of professional ideals."

Medical practice has passed in two decades from the jog trot era of the horse and buggy to the frenzied era of the high-speed motor car and the aeroplane. Increase in scientific details and in cost and complexity of equipment has been proportionate to increased rate of transportation. The doctor of twenty years ago was hard worked. His mental capacity was heavily taxed. Medical

(Continued on Page 40)



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TWENTY-FIVE YEARS AGO

(Continued from Page 40)

men of today are as well endowed mentally and physically as their predecessors, but the capacity of the human brain has not changed. Doctors are not today equal to seeing several times as many patients, considering twice as many details on each case, and covering at least five times as much literature as their fathers did in the same number of hours. They become too jaded to cerebrate. Mechanical routinism is the natural outcome. . . .

The Sunflower Ordnance Works, at De Soto, Kansas, received this missive: "Sirs: I hear you-all are looking to sell government surplus funds. I calculate I could use some of them funds. Please send information for bidding on same."—*This Week Magazine.*

BOARD OF MEDICAL EXAMINERS

(Continued from Page 418)

McPheeter's petition for a writ of mandate in the same position it was in Judge Conway's court prior to his decision, and makes the State's motion to strike out the petition a matter subject for further proceedings. . . . In support of a writ, the Fresno doctor's counsel said Dr. McPheeters appeared in February, June and October, 1944, and February, 1945, before the State Board in Los Angeles, Sacramento and San Francisco without evidence being presented on three charges of performing illegal operations." (Fresno, California, *Bee,* April 17, 1946.)

"Physiotherapist Held on Code Act Charge—Charged with violating the professional standards act, Gordon C. Heap, a physiotherapist of 1335 Waterman Avenue, was

(Continued on Page 44)

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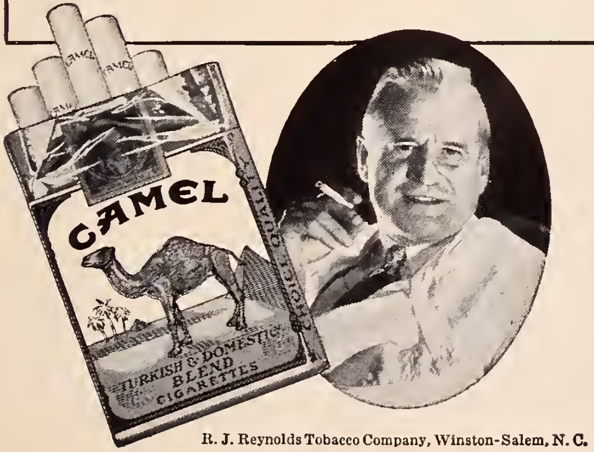

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 40)

arrested yesterday. . . . Mr. Heap is accused of offering to give asserted medical treatments, whereas he does not hold a certificate as a physician. The charge was sworn to by Maynard Youngs, investigator for the State Board of Medical Examiners. . . . Mr. Heap was released on his own recognizance pending a hearing." (San Bernardino, California, *Sun*, April 10, 1946.)

"Three Arraigned After 'Cosmic Ray' Arrests—Three men, arrested on suspicion of violating the State Medical Practices Act for operating open air 'Cosmic Ray' centers near Compton, were to be arraigned at 10 a.m. today, in the Huntington Park Justice Court before Judge Stanley Moffatt. . . . Two squads of 20 officers each raided both centers yesterday at a field on 223rd St., two miles south of Alameda St., and another in a gully along Atlantic Blvd., between North Long Beach and Lynwood. . . . Arrested on a warrant issued by Judge Moffatt were Paul and Charles Beebe, charged with eight violations involving the State Medical Practices Act, Pure Food and Drug Act, having no permit to sell foodstuffs, and failing to maintain rest-room facilities; and Ralph C. Hylton, accused on five counts involving the Medical and Food and Drug Acts and false advertising. . . . Sandwiches, wheat, water, ice operators said to have been treated by cosmic rays were seized as evidence along with a 'cosmic ray' machine. More than 100 persons, most of them elderly, were cluttered around the Beebe brothers' trailers taking the 'treatments.'" (Hollywood, California, *Citizen-News*, April 13, 1946.)

BOOKS RECEIVED

(Continued from Page 12)

Agnosia, Apraxia, Aphasia — Their Value in Cerebral Localization. By J. M. Nielsen, M.S., M.D., F.A.C.P., Associate Clinical Professor of Medicine (Neurology), University of Southern California; Senior Attending Physician in Neurology and Assistant in Neuropathology, Los Angeles County Hospital, Los Angeles, California. Cloth. Second edition completely revised. Price, $5.00. Pp. 292, with 59 illustrations. New York, London: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1946.

Cornell Conferences on Therapy. Volume One. Edited by Harry Gold, M.D., Managing Editor; David P. Barr, M.D., Eugene F. DuBois, M.D.; McKeen Cattell, M.D., and Charles H. Wheeler, M.D. Cloth. Price, $3.25. Pp. 322. New York: The MacMillan Company, 1946.

Clinical Laboratory Diagnosis. By Samuel A. Levinson, M.S., M.D., Ph.D., Director of Laboratories, Research and Educational Hospitals, Chicago, Illinois; Professor of Pathology, University of Illinois College of Medicine, and Robert P. MacFate, Ch.E., M.S., Ph.D., Assistant Director of Laboratories, Research and Educational Hospitals, Chicago, Illinois; Assistant Professor of Pathology, University of Illinois College of Medicine. Cloth. 3d edition, thoroughly revised. Pp. 971, illustrated with 192 engravings and 15 plates, 7 in color. Philadelphia: Lea & Febiger, 1946.

Modern Management in Clinical Medicine. By F. Kenneth Albrecht, M.D., S.A. Surgeon, U. S. Public Health Service; Kansas State Tuberculosis Consultant; formerly Clinical Director, U. S. Marine Hospital, Baltimore, Md. Cloth. Price, $10.00. Pp. 1238, illustrated. Baltimore: The Williams and Wilkins Company, 1946.

Diseases of the Adrenals. By Louis J. Soffer, M.D., Adjunct Attending Physician, the Mount Sinai Hospital,

(Continued on Page 48)

Silencer for midnight phones

When pediatricians prescribe 'Dexin' brand High Dextrin Carbohydrate for their infant patients, the physicians are no longer wakened so frequently by frantic late-night phone calls. Because of the high dextrin content, 'Dexin' feedings tend to (1) diminish intestinal fermentation and the resultant colic and diarrhea and (2) promote the formation of soft, flocculent, easily digested curds.

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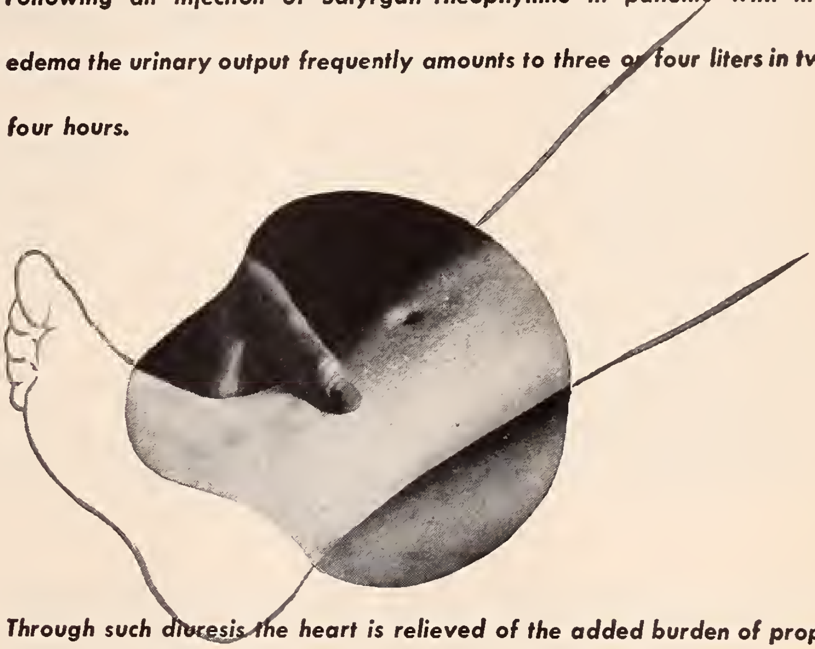

Through such diuresis the heart is relieved of the added burden of propelling the blood through the compressed blood vessels. The blood volume is decreased, and in all probability the efficiency of the heart is increased by elimination of myocardial edema.

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BOOKS RECEIVED

(Continued from Page 44)

New York City. Cloth. Pp. 304, illustrated with 42 engravings and two colored plates. Philadelphia: Lea & Febiger, 1946.

The Venous Pulse and Its Graphic Recording. By Franz M. Groedel, M.D., Attending Cardiologist, Beth David Hospital; Cardiologist, St. Anthony's Hospital; Consulting Cardiologist, Einhorn Department, Lenox Hill Hospital, New York. Cloth. Price, $5.50. Pp. 223 with 7 illustrations and 290 tracings on 114 figures. New York: Brooklyn Medical Press, 1946.

Cosmetics and Dermatitis. By Louis Schwartz, M.D., Medical Director, U. S. Public Health Service; Chief, Dermatoses Section, Division of Industrial Hygiene; Adjunct Professor in Dermatology, Georgetown University School of Medicine; Associate Clinical Professor in Dermatology and Syphilology, New York University College of Medicine; Consultant, Office of Price Administration, and Samuel M. Peck, M.D., Medical Director (R) U. S. Public Health Service; Associate Attending Dermatologist, Mt. Sinai Hospital, New York City; Attending Dermatologist and Syphilologist, Skin and Cancer Unit of the New York Postgraduate Medical School and Hospital of Columbia University; Diplomate of the American Board of Dermatology and Syphilology. Cloth. Price, $4.00. Pp. 189. New York, London: Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 1946.

Trends Indicate Specialist Is Displacing Family Doctor

Two Physicians Lament Lowering of Prestige of General Practitioner In Regimented Medicine and Suggest Remedies

Overemphasis on the importance of the specialist and the resultant lowering of prestige of the general prac-

(Continued on Page 52)

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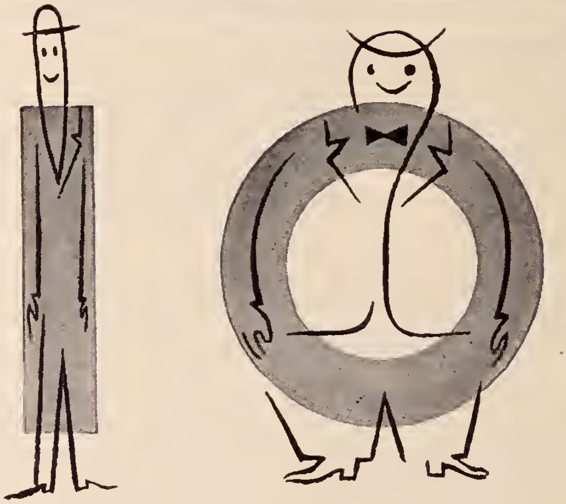

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[1] Handbook of Nutrition, Chicago A.M.A., 1943, p. 557.

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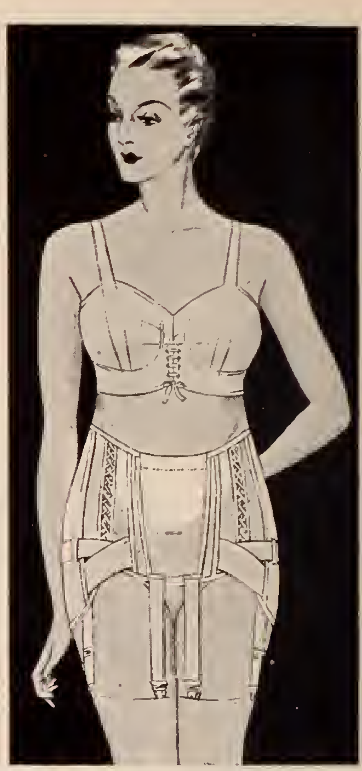

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Trends Indicate Specialist Is Displacing Family Doctor

(Continued from Page 48)

titioner have led two Arkansas doctors to propose a plan to check the trend.

Writing in the June 8 issue of *The Journal of the American Medical Association*, S. A. Thompson, M.D., and S. B. Thompson, M.D., of Camden, suggest that the following steps be taken:

1. *Recognition of the general practitioner by regimented medicine (this includes the medical service of the military services, the Veterans' Administration, medical teaching centers, certain industrial medical plans and other similar systems) through:*

A. Staff appointments for general practitioners in teaching centers; B. general practice services in teaching, military and Veterans' Administration hospitals; C. perpetuation of the Veterans' Administration's system for care of the veteran in his local community with general practitioners participating.

2. *Elimination of causes for criticism of the general practitioner through:*

A. Standardization and improvement of training of general practitioners; B. limitation of the work of the general practitioner to that for which he is adequately trained.

3. *Organization of general practitioners to implement these proposals.*

At present there are some 160,000 practicing physicians, of whom slightly more than 20,000 are certified

(Continued on Page 56)

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"knowing" comes from "doing"

*With
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Trends Indicate Specialist Is Displacing Family Doctor

(Continued from Page 52)

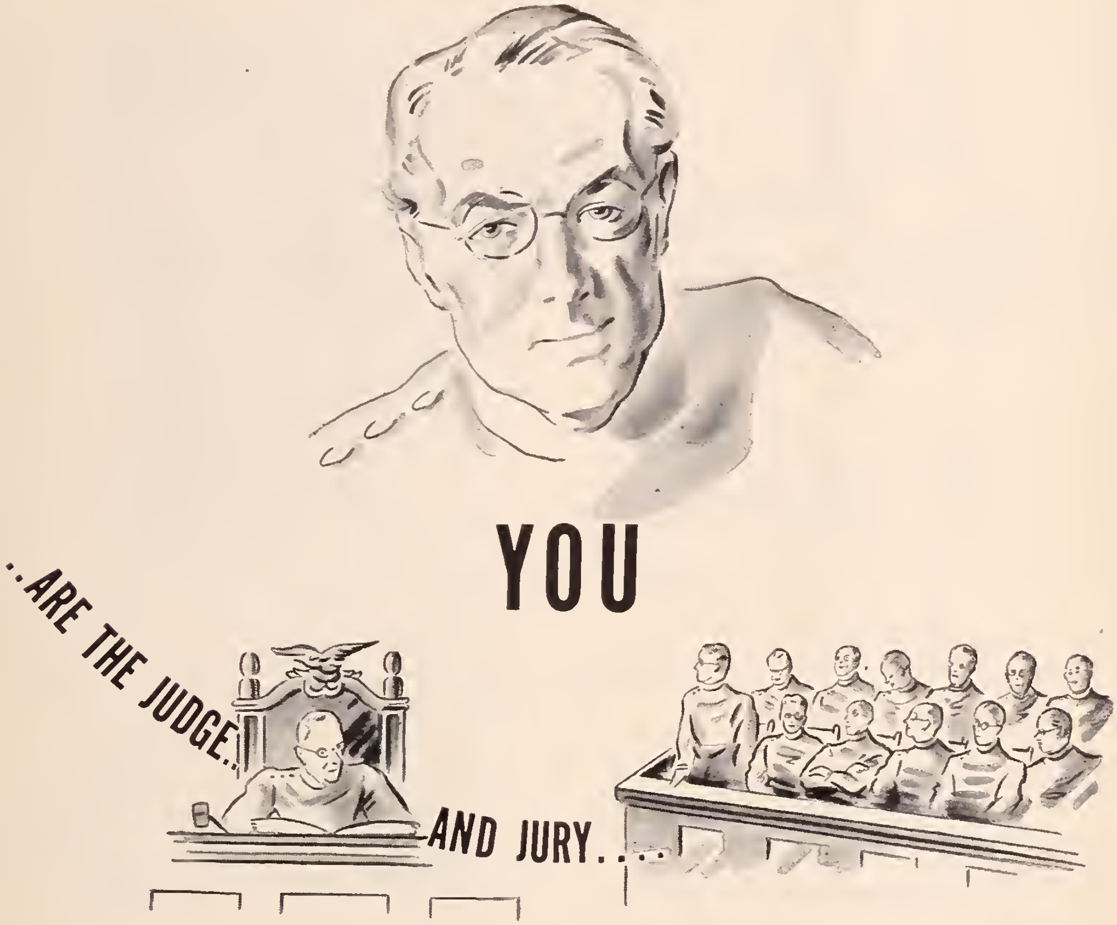
by the various specialty boards as qualified in their chosen fields. This makes a ratio of one specialist to eight general practitioners.

Some of the examples listed by the authors in illustration of the present trend toward specialization are:

"The Pepper bill now before Congress would perpetuate the maternal and infant care of the Emergency Maternity and Infant Care Program for all families. A committee from the advisory board to the Children's Bureau recommended that only certified specialists be allowed to participate in this program. The advisory board did not accept the committee's report, but it is indicative of the trend of thinking now in progress.

"In the medical teaching centers where our students, interns and residents are trained and where so many of our low income group receive their medical care, a similar trend is apparent. . . . Each patient is seen in a spe-

(Continued on Page 62)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* The following excerpt appeared in J.A.M.A., Feb. 24, 1945, p. 460:
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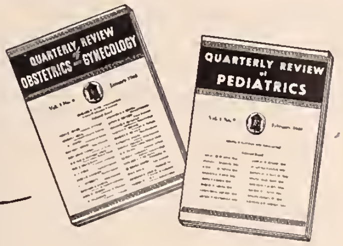

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Trends Indicate Specialist Is Displacing Family Doctor

(Continued from Page 56)

cialty clinic or admitted to a specialty service. All cases, including the most trivial and routine cases handled daily by the general practitioner in private practice, are treated by specialists or under the supervision of specialists.

"More and more prominence is being assumed in private practice by the group clinics, and the trend in these appears to be steadily toward specialization."

Presenting the case for the general practitioner the two physicians say:

"The economic waste involved in specialty care for routine conditions has already been mentioned, but, more positively, what has the general practitioner accomplished? During the past 50 years the life expectancy has been increased from 33 to 60 years, maternal and infant mortality has been lowered tremendously, many infectious diseases have been all but eliminated, and numerous other great strides have been made."

Summing up the case for personalized medicine, the physicians say that during the last 40 years "one may safely conclude that well over 90 per cent of medical care to patients has been given by general practitioners. . . . Has the general practitioner not been successful in bringing the advances of medical science to the patient? Surely this implies that he is capable of treating patients."

Research on Airplane Crash Injuries Results in New Safety Measures

More ductile instrument panels, control wheels, and the removal of structures which repeatedly cause injury to knees are some of the safety measures initiated as a result of extensive research made on injuries suffered in airplan crashes, according to an editorial in the June 8 issue of *The Journal of the American Medical Association.*

The study was begun in 1942 by the National Research Council at Cornell University Medical College working with the Safety Bureau of the Civil Aeronautics Board and study groups in the Army Air Forces and the Navy.

"Reports which physicians have returned to crash injury research of the National Research Council already have brought about notable improvements," the editorial states. "Instrument panels, for example, which were reinforced so solidly that they demolished the head under heavy impact blows are now being redesigned. By using ductile instead of solid structure, the energy of heavy 'fatal' blows can be distributed and absorbed without fracturing the skull—frequently with only mild or moderate evidence of 'concussion.'

"Control wheels of cast materials which have been found broken in crashes causing puncture of the chest with intrathoracic lesions now are being replaced by wheels which will support the chest and cause lesser injuries of the chest under extremely severe conditions Structures which repeatedly caused massive injuries of the knees are being eliminated and elements substituted which moderate the chance of such injuries."

To aid in its project the "National Research Council is asking physicians to help in obtaining data on the nature, location and severity of injuries sustained by victims of 'survivable' aircraft accidents."

It is the Council's belief that "people frequently survive serious crashes without dangerous injuries. . . . Study of the factors that allow survival may aid in lessening dangers in aircraft and automobile accidents."

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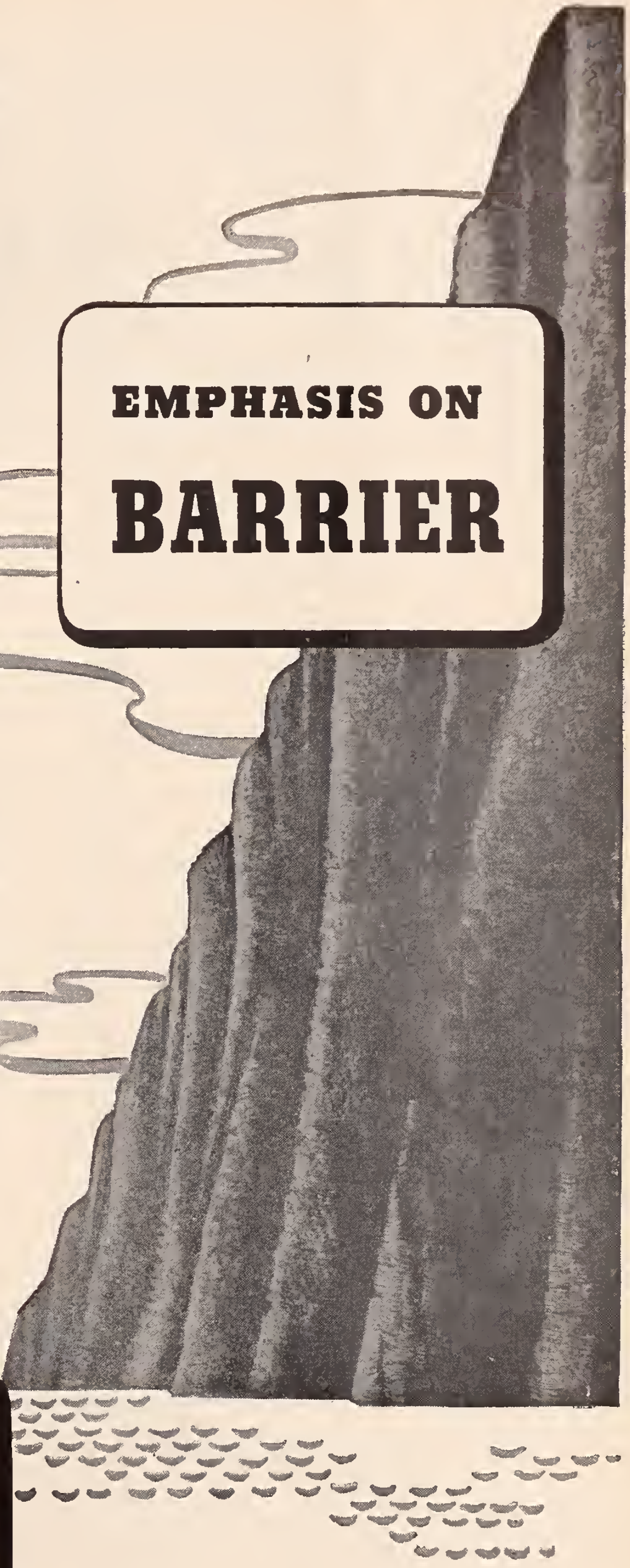
1. Clinic Reports: Planned Parenthood Services in the United States. Human Fertility 10: 25 (Mar.) 1945.
2. Dickinson, R.L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
3. Warner, M.P.: J.A.M.A. 115: 279 (July 27) 1940.



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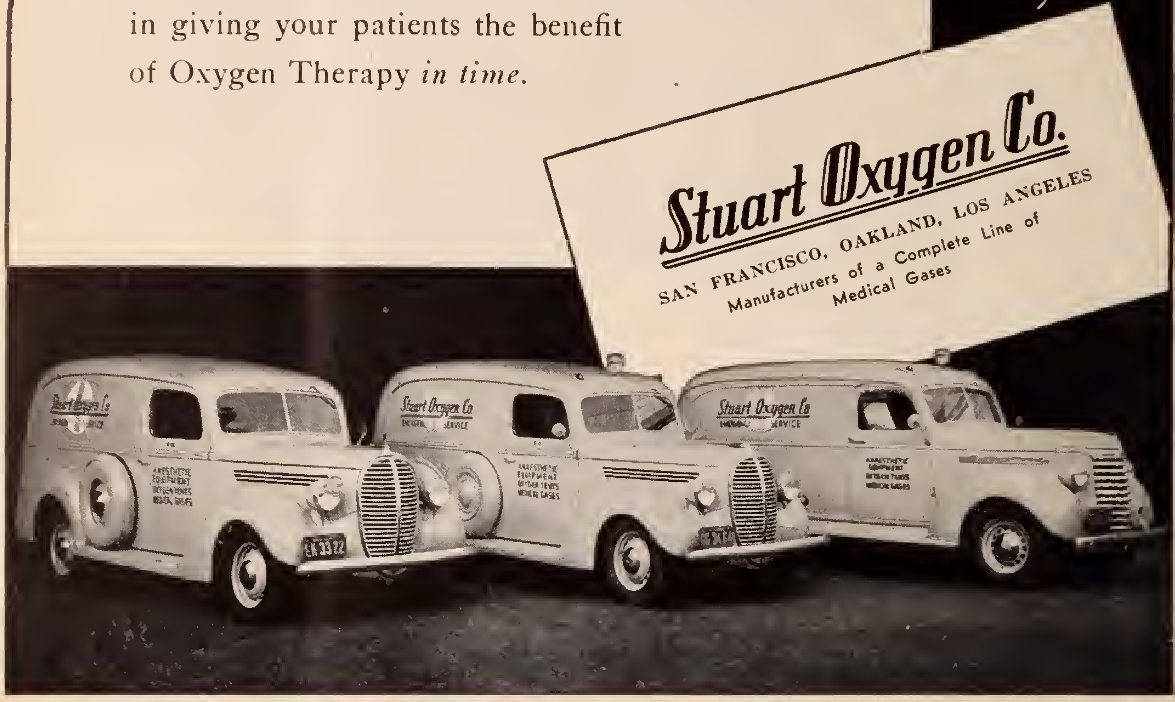

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ACCURATE DOSAGE . . . CONVENIENT FORM . . . ECONOMY

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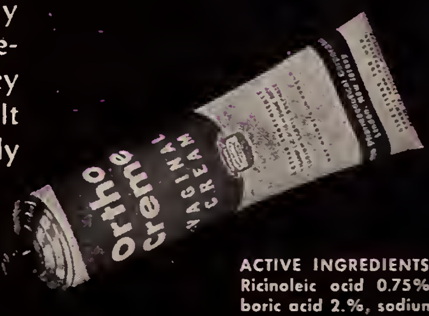
HAACK LABORATORIES, INC., 1415 S. W. HARBOR DRIVE, PORTLAND 1, OREGON

AN *Esthetic* MASTERPIECE . . .

The velvety white smoothness and esthetic appeal of Ortho-Creme Vaginal Cream have made it the contraceptive of choice for women who prefer a cream to a jelly. • ORTHO-CREME Vaginal Cream, like ORTHO-GYNOL Vaginal Jelly, is effectively and promptly spermicidal, readily miscible with vaginal secretions...yet is distinctively different in consistency . . . with the touch of a fine cosmetic cream. It is non-irritating to tissues and may be safely used over prolonged periods.

ORTHO PHARMACEUTICAL CORP., LINDEN, N. J.
Manufacturers of gynecic pharmaceuticals



ACTIVE INGREDIENTS:
Ricinoleic acid 0.75%, boric acid 2.%, sodium lauryl sulphate 0.28%.

ortho-creme
WHEN A CONTRACEPTIVE CREAM IS PREFERRED

I WANT MORE PABLUM!

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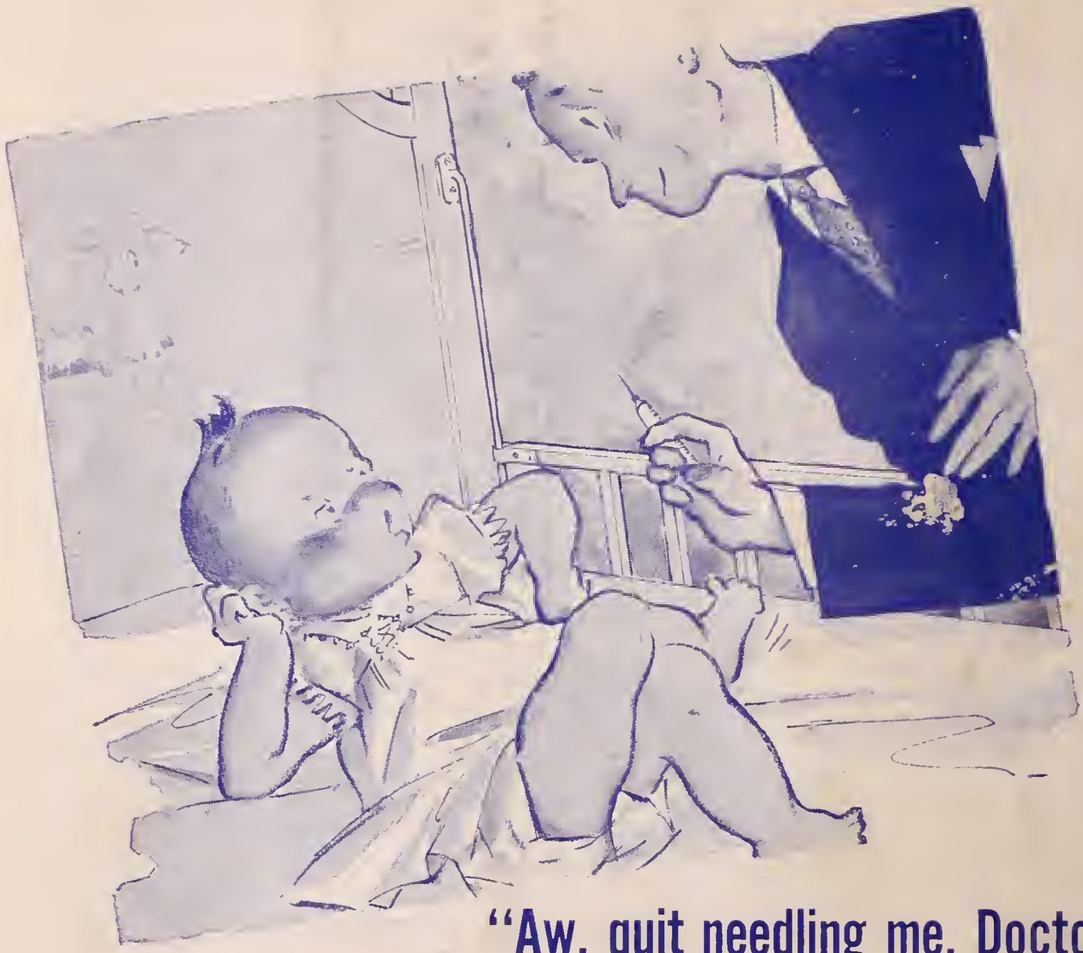
"Aw, quit needling me, Doctor!"

With Cutter D-P-T, only 3 shots needed to immunize against diphtheria, pertussis, tetanus

Why inflict 9 shots — when only 3 of Cutter D-P-T are equally effective? Immunity against diphtheria, pertussis and tetanus is at least as great as when each antigen is given alone!

Every cc. of D-P-T contains more than a human dose each of diphtheria and tetanus toxoids, plus 40 billion pertussis organisms. Grown on *human blood media*, pertussis organisms for D-P-T are guaranteed to be in Phase 1.

In addition, purified toxoids and extremely high pertussis count yield a vaccine so concentrated that your dosage schedule with D-P-T is only 0.5 cc., 1 cc., 1 cc. Thus, you eliminate undue pain and tissue distention.

Cutter D-P-T (Alhydrox)—in contrast to alum precipitated vaccines—presents less pain on injection, and avoids almost entirely both persistent nodules and sterile abscesses. You, and your patients, will appreciate its many advantages.

PRICES:

D-P-T (Plain)—		D-P-T (Alhydrox)—	
2½ cc.	$2.75	2-1 cc. vials . . .	$2.75
10 cc., 4 immunizations	$5.00	10 cc., 5 immunizations	$6.25

Cutter Laboratories, Berkeley, California
Chicago • New York

CUTTER

Fine Biologicals and
Pharmaceutical Specialties

The New York Academy of Medicine

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